

# MAINSTREAMING SPIRITUAL CARE IN HEALTHCARE ORGANIZATIONS

How Spiritual Care Providers  
Address Workforce Challenges,  
Access to Care & Patient Experience



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# Mainstreaming Spiritual Care in Healthcare Organizations

## How Spiritual Care Providers Address Workforce Challenges, Access to Care & Patient Experience

Kelsey B. White, PhD, BCC  
Assistant Professor  
Virginia Commonwealth University

Naana Adjei, MPH, RD  
Health Services Organization and Research PhD Student  
Virginia Commonwealth University

Aubrey K. Smith, Jr.  
Virginia Commonwealth University

Laura McClelland, PhD  
Associate Professor  
Virginia Commonwealth University

Marilyn Barnes, MS, MA, MPH, BCC  
Associate Professor and Chair  
Virginia Commonwealth University

Ralph “Ron” Clark, MD  
Chief Medical Officer Ambulatory Care Services  
Virginia Commonwealth University Health System

Wendy Cadge, PhD  
President and Professor  
Bryn Mawr College



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## EXECUTIVE SUMMARY

The *Mainstreaming Spiritual Care in Health Care Organizations* project explored – through a scoping review of the literature- how spiritual care impacts healthcare delivery. It described how healthcare executives can maximize their utilization of spiritual care providers to enhance workforce wellbeing, patient experience, and access to care. Spiritual care providers support all persons regardless of their religious or spiritual identity. They *are members of the interdisciplinary team, employed by health organizations, and ideally board-certified through national training organizations.*<sup>1</sup> Recommendations and the evidence on which they are based fall into three main groups.

### 1. Workforce Wellbeing

Workforce challenges were identified as the number one concern of community hospital CEOs in the American College of Healthcare Executives’ 2022 survey.<sup>2</sup> Clinician retention, burnout, and turnover continue to strain healthcare organizations even as they work to recover from the Covid-19 pandemic.<sup>3</sup> Spiritual care interventions offer opportunities to improve organizational care to employees as executives navigate personnel shortages, employee burnout, and employee retention. We recommend the following spiritual care interventions to address workforce challenges:

Intervention	Description	Learn More
<b>Code Blue Response Strategies</b>	Spiritual care clinicians support staff during resuscitation events. Examples include leading a silent pause after a death to process and honor the death.	<a href="#">Clark 2005</a> <a href="#">Copeland 2016</a> <a href="#">Mureau-Haines 2017</a> <a href="#">Teague 2019</a> <a href="#">Tennyson 2023</a>
<b>Tea for the Soul, Chi Cart Ministry, Chi Time</b>	Mobile cart with tea, healthy snacks, music, words of comfort, and aromatherapy for staff stress reduction. Applies tenets of a Japanese tea ceremony to encourage group gathering.	<a href="#">Keogh 2017</a> <a href="#">Keogh 2020</a> <a href="#">Callis 2022</a>
<b>Family Communication Coordinator</b>	The FCC spiritual care clinical role decreases stress and nurse role ambiguity by facilitating the communication between caregivers of potential organ donors and the organ procurement organization. The FCC spiritual care clinician facilitates communication, coordinates meetings, and monitors patients’ cognitive functioning.	<a href="#">Dodd-McCue 2005</a> <a href="#">Dodd-McCue 2004</a>

<sup>1</sup> Spiritual care board certification requires a graduate degree, accredited clinical training (ACPE CPE), 2,000 hours of work experience, endorsement, and sitting before a certification committee. Organizations that certify spiritual care providers include the Association of Professional Chaplains, National Association of Catholic Chaplaincy, Neshama Association of Jewish Chaplains, and Spiritual Care Association.

<sup>2</sup> American College of Healthcare Executives. (2023). *Survey: Workforce Challenges Cited by CEOs as Top Issue Confronting Hospitals in 2022*. American College of Healthcare Executives. <https://www.ache.org/about-ache/news-and-awards/news-releases/survey-workforce-challenges-cited-by-ceos-as-top-issue-confronting-hospitals-in-2022>

<sup>3</sup> Mazurenko, O., Collum, T., Ferdinand, A., & Menachemi, N. (2017). Predictors of Hospital Patient Satisfaction as Measured by HCAHPS: A Systematic Review. *Journal of Healthcare Management*, 62(4), 272–283. <https://doi.org/10.1097/JHM-D-15-00050>

## 2. Patient Experience & Patient Satisfaction

There is an established association between patient experience/patient satisfaction and clinical effectiveness in various clinical settings.<sup>4</sup> Patient experience is also an important measure of care quality that directly impacts Value Based Purchasing reimbursement by the Centers for Medicare and Medicaid Services.<sup>5,6</sup> We recommend the following spiritual care interventions to improve patient experience and patient satisfaction:

Intervention	Description	Learn More
<b>Dignity Therapy</b>	Psychotherapeutic interview intervention that produces a legacy document for patients' caregivers. The intervention aims to provide spiritual comfort through verbal processing of their story, find meaning in their illness, and create a legacy document for their family.	<a href="#">Al Yacoub 2023</a> <a href="#">Wilkie 2024</a>
<b>Spiritual Legacy Intervention</b>	A comprehensive, chaplain-led spiritual life review process that includes a spiritual legacy interview and development of a personalized spiritual legacy document for patients. The document acts as a way to pass down their important life stories to the important people in their lives.	<a href="#">Piderman 2015</a> <a href="#">Piderman 2017</a> <a href="#">Piderman 2020</a>
<b>Spiritual Care Assessment &amp; Intervention (SCAI)</b>	Semi-structured framework with guidelines on spiritual assessment (4 dimensions), 26 interventions, and documentation of spiritual care. Addresses 4 key dimensions: Meaning and Purpose, Relationships, Transcendence and Peace, and Self-Worth and Identity.	<a href="#">Perez 2022</a> <a href="#">Torke 2023</a>
<b>This is My Story (TIMS)</b>	A short summary of a patient's identify / story that is uploaded to the patient's medical records to aid in personalization of care. Medical providers, nurses and other team members can listen to the short recording as a way of personalizing their care.	<a href="#">Tracey 2021</a> <a href="#">Tracey 2023</a> <a href="#">Wilson 2023</a>

### Access to Care

Access to timely and appropriate health services remains an ongoing challenge across the industry. Rural areas consistently face challenges related to the availability and affordability of healthcare services.<sup>7</sup> Behavioral and mental health issues including anxiety, depression, and substance use disorders are associated with 75% of

<sup>4</sup> Navarro, S., Ochoa, C. Y., Chan, E., Du, S., & Farias, A. J. (2021). Will improvements in patient experience with care impact clinical and quality of care outcomes?: a systematic review. *Medical Care*, 59(9), 843-856.

<sup>5</sup> Mazurenko, O., Collum, T., Ferdinand, A., & Menachemi, N. (2017). Predictors of Hospital Patient Satisfaction as Measured by HCAHPS: A Systematic Review. *Journal of Healthcare Management*, 62(4), 272-283. <https://doi.org/10.1097/JHM-D-15-00050>

<sup>6</sup> Doyle, C., Lennox, L., & Bell, D. (2013). A systematic review of evidence on the links between patient experience and clinical safety and effectiveness. *BMJ Open*, 3(1), e001570. <https://doi.org/10.1136/bmjopen-2012-001570>

<sup>7</sup> Oyeka, O., Ullrich, F., Shane, D., & Mueller, K. J. (2023). Changes in Service Offerings Post-System Affiliation in Rural Hospitals. *RUPRI Center for Rural Health Policy Analysis, Brief 2023-2*. <https://rupri-public-health.uiowa.edu/publications/policybriefs/2023/Hospital%20System%20Participation%20and%20Services.pdf>

primary care visits<sup>8</sup>, and yet most Americans with mental health issues are unable to access behavioral health treatment.<sup>9</sup> People managing such issues also face greater risk of chronic diseases and complex challenges within the social determinants of health.<sup>10</sup> Spiritual care services in outpatient and clinic settings can help address behavioral health concerns and access to care. We recommend the following spiritual care interventions to address behavioral health challenges and access to care:

Intervention	Description	Learn More
<b>Spirituality Groups</b>	Group sessions using discussions of various spiritual topics or approaches such as Sacred Story or peer support programs. In some versions, the spiritual care clinician may also use a deck of cards, patients describe their belief of how God feels about them and what they would have to do for God to feel glad about them. Spiritual Care Clinician guided group meditation using scripted guiding comments.	<a href="#">Blum 2021</a> <a href="#">Boehm 2020</a> <a href="#">Flemming 2023</a> <a href="#">Grossoehme 2001</a> <a href="#">Franco 2023</a> <a href="#">Kidd 2001</a> <a href="#">Simgelsky 2022</a> <a href="#">Rummans 2006</a> <a href="#">Timbers 2021</a> <a href="#">Wing Yee Wong 2019</a>
<b>Telechaplancy</b>	Spiritual care clinicians deliver interventions by video conference or phone to patients who report religious/spiritual need during screening.	<a href="#">Sprik 2019</a> <a href="#">Sprik 2021</a> <a href="#">Sprik 2023</a> <a href="#">Winiger 2023</a> <a href="#">Valenti-Hein 2022</a>
<b>MICAH HEAL Project</b>	Population health initiative that used a spiritual care provider to act as a facilitator, instructor, and bridge between community health advisors, faith-based organizations, and a health system.	<a href="#">Marin 2019</a> <a href="#">Marin 2022</a>

### Conclusions

Spiritual care interventions impact workforce wellbeing, patient experience, and access to care (as described above). These are in addition to general spiritual care which, evidence shows, improves healthcare delivery by:

- Attending to spiritual and psychosocial distress
- Providing bereavement and grief support
- Incorporating religious / spiritual rituals and resources
- Facilitating medical decision making and advanced care planning
- Enhancing interdisciplinary communication and trust
- Prioritizing cultural identities and dynamics in care

<sup>8</sup> Schrage S. (2021). Exploring Factors That Affect Rural Health. *Wisconsin Medical Journal*, 120(3), 169–170.

<sup>9</sup> Chatterjee, R. (2023, December 13). Most Americans with mental health needs don't get treatment, report finds. *Health News from National Public Radio*. <https://www.npr.org/sections/health-shots/2023/12/13/1218953789/most-americans-with-mental-health-needs-dont-get-treatment-report-finds>

<sup>10</sup> Bradley, E.H. & Taylor, L.A. (2013). *The American Health Care Paradox*. PublicAffairs Publishers.

Healthcare executives can improve workforce retention and wellness issues, patient experience and quality, and access to care through greater collaboration with their spiritual care leadership.

**Project Team**

The [Mainstreaming Spiritual Care leadership team](#), which included a spiritual care researcher, health services researcher, spiritual care manager, and sociologist, conducted a scoping review to identify spiritual care interventions and approaches to influence healthcare delivery while engaging in ongoing dialogue with leaders from across the United States. [Those leaders](#) included health care executives and within spiritual care administration. The full report includes 6 tables, 3 figures, and 8 appendices.

# Mainstreaming Spiritual Care in Healthcare Organizations

## How Spiritual Care Providers Address Workforce Challenges, Access to Care & Patient Experience

### Introduction

Spiritual care providers (SCPs) or chaplains are the professional staff members in most U.S. health systems who address spiritual and religious needs, provide emotional support, and help clinicians navigate religion and spirituality's complex role in medical decision making.<sup>1-4</sup> Many people experience spirituality in seeking ultimate meaning, purpose, transcendence, and relating to themselves and their broader communities.<sup>5</sup> SCPs attend to spiritual dimensions of healthcare vital to wholistic patient-centered care. It is important for health systems and public health sectors to address spiritual health and spiritual needs, especially for those with chronic, complex, or terminal illnesses, based on evidence-base which shows such support impacts health and wellbeing.<sup>6,7</sup>

A national survey conducted in 2019 showed that 21% of Americans had contact with a SCP in the past two years – more than half of those contacts occurred in healthcare organizations.<sup>8</sup> Before the pandemic, a study of healthcare executives showed that many did not understand spiritual care and, in some cases, saw its value more for staff than for patients and families.<sup>9,10</sup> This project reports on a scoping review of empirical research studies to identify SCPs' work and evaluate how these approaches contribute to the wider delivery of healthcare services. Such knowledge can inform how healthcare executives address pressing issues in healthcare including workforce challenges, patient experience, and access to care. We align our findings with key challenges faced by healthcare executives.<sup>11</sup>

### Persistent Challenges in Healthcare Management

**Workforce challenges** were the number one concern of community hospital CEOs in the American College of Healthcare Executives' 2022 survey.<sup>12</sup> Healthcare clinician burnout and turnover were a concern prior to the Covid-19 pandemic, and the pandemic and disruptions in the labor market accelerated the strain on healthcare delivery even further.<sup>13,14</sup> Executives identified workforce stressors such as personnel shortages, employee burnout, and challenges with managing remote staff. The workforce impacts associated with the pandemic include increased competition with other industries on wages and benefits, increased turnover or intent to quit, and shifts in employees' values and work preferences towards at least partly working from home.<sup>14</sup>

The adoption of the Affordable Care Act presented two streams of challenges for healthcare executives in relation to **access to care**: expanding service offerings to cover higher numbers of clients, particularly previously uninsured, low-income individuals, and unintended consequences of perceived challenges with health insurance exchanges.<sup>15</sup> Affiliations of rural hospitals with larger health systems more than doubled in the 2010s compared to the 2000s, accompanied by access-related challenges such as increased prices, removal of

essential services, and the closure of other smaller hospitals.<sup>16</sup> An estimated 100-140 rural hospitals closed between 2010 and 2022, leaving rural communities without nearby sources of care for healthcare emergencies.<sup>16,17</sup>

The focus on **patient experience and satisfaction** by healthcare executives is partly motivated by changes in reimbursement by the Centers for Medicare and Medicaid Services to focus on patient satisfaction as reported in Hospital Consumer Assessment of Healthcare Providers and Systems survey (HCAHPS).<sup>18</sup> Providers and researchers pay close attention to patient experience and satisfaction scores, often gathered through surveys, as an indicator of the care people receive. These perceptions become an economic and survival concern for organizations as they influence terming payments for services.<sup>18</sup> Researchers have established associations between patient experience and clinical effectiveness for various diseases and clinical settings.<sup>19</sup> While some studies have demonstrated an association between the provision of spiritual care and higher patient experience scores,<sup>20,21</sup> this literature review will consider if any other spiritual care interventions could potentially aid in addressing this indicator of organizational performance.

## Methodology

To analyze how spiritual care could address ongoing challenges in healthcare systems, we conducted a scoping review of the literature to see what spiritual care interventions exist and how they relate to the key problems healthcare executives face. We did this with the support of an Advisory Committee (AC) that included eight health care executives and four chaplaincy leaders (see Appendix 1). We used PRISMA guidelines for Scoping Reviews<sup>22</sup> and previously published literature reviews on related topics<sup>23-26</sup> to ensure methodological rigor and consistency with existing knowledge. The protocol was not registered.

## Data Extraction & Screening

Search terms for the scoping review are available in the appendix 2 (eTable 1). The team searched the following databases:

- Academic Search Complete
- CINAHL
- PsychInfo
- Pubmed/Medline
- Web of Science

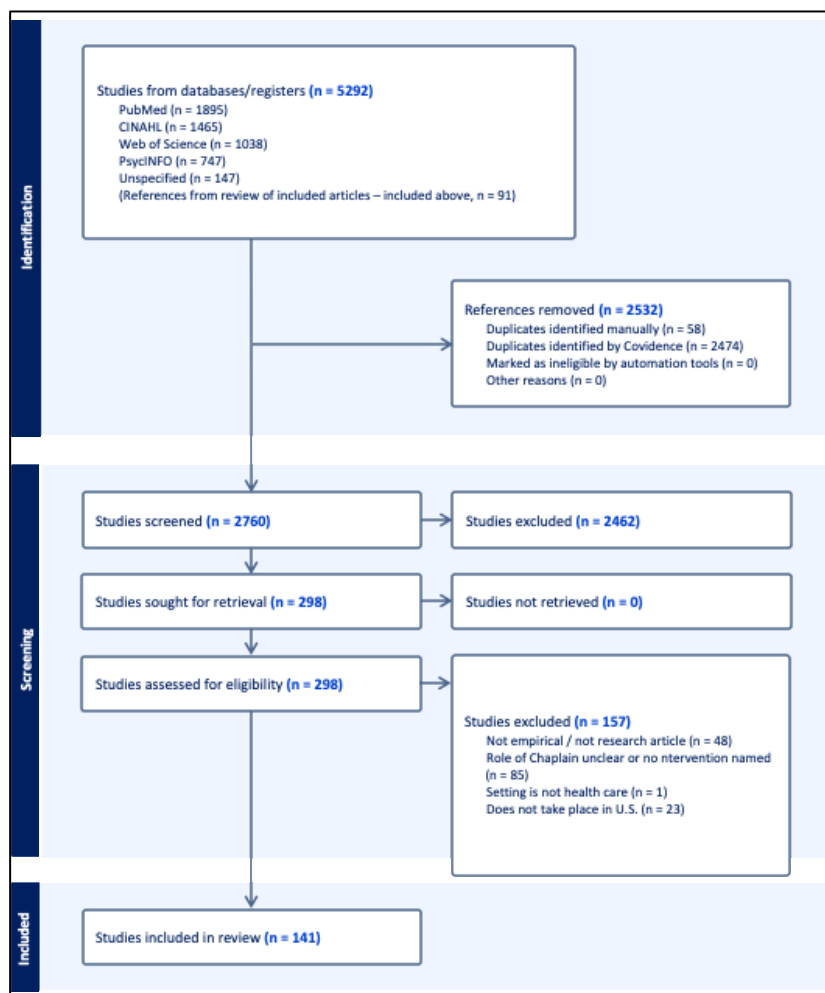
Articles were excluded if they were not written in English or took place outside of the United States. We analyzed articles published after 1998 as that is the year that “evidence-based care” first occurred in the published literature about chaplaincy.<sup>27,28</sup> We included articles that were peer reviewed and empirical research articles; we excluded book chapters, dissertations, conference abstracts, and opinion pieces. Articles were included if they took place in any health care setting. We did not exclude based on population.

After full text review, we screened 91 additional articles to review for inclusion (from reference lists of other reviews and included articles) and added 27 to our database for team review. The most recent database search occurred on February 15, 2024.

During full text review, we excluded articles that did not specify how a chaplain intervened in each scenario (e.g., articles that simply spoke of chaplain care versus no chaplain care, interdisciplinary interventions with no clear chaplain role identified). The articles were included if they named a specific intervention chaplains led or participated in as part of the healthcare team. We also included articles that specified the details of the spiritual care provided. Articles that were qualitative or exploratory in nature that identified the details of the chaplains' activities (whether in the methods or results) were also included.

Three team members (KW, NA, AS) screened the articles. Two team members screened articles at the title/abstract screening phase and two at the full text screening phase; when disagreements occurred, the team of three met to resolve the disagreement via consensus. One team member extracted article data and a second reviewed the extraction for accuracy. The PRISMA Diagram of the screening process is available in Figure 1.

Figure 1. PRISMA Diagram for Article Selection Process



## Data Items Extracted

From each study, the team extracted the location of the study, the study aim, the study design, study sample, healthcare delivery setting, type/name of intervention (if applicable), measures, outcomes, and if the article discussed the role of a healthcare administrator. For descriptive purposes, we categorized the articles according to the discipline of the publishing journal (e.g., nursing, chaplaincy, etc.) and year of publication (five-year increments). We tracked the study sample according to whether individuals were patients, caregivers (friends, family, and personal loved ones of patients), clinicians, or SCPs. Clinicians were considered those who work in direct patient care.

## Data Analysis

We sorted articles according to whether they named a formal intervention or reported on general spiritual care (with details of what that meant for those investigators). Any article that did not name a formal intervention and provided details of the SCPs’ activities for their study was grouped under general spiritual care.

Articles with formal interventions were examined according to their target population, the problem they aimed to address or explore, and the study rigor. Study rigor refers to the extent to which a study design aims to identify cause and effect; the more experimental a design, the more generalizable researchers describe their findings or point to how one factor causes another.<sup>29</sup> Additionally, experimental study designs may also include controlling for extraneous factors that could influence their outcome of interest. As detailed in Table 1, more experimental designs were given a higher rigor score.

Table 1. Rigor score for the range of study designs

	Study Design	Assigned Rigor Score
↑ More Exploratory	Case Study	0
	Qualitative	1
↓ More Experimental	Cross Sectional Retrospective of existing data Pilot or feasibility study	2
	Mixed Methods	3
	Pre/Post Design Quasi-experimental	4
	Experimental Randomized Control Trial Longitudinal	5

To directly answer our question, we examined each article’s problem, study aim, and outcomes in order to match the efforts to one or more than one of Becker’s *Top Ten Problems Keeping Healthcare Administrators Up at Night*.<sup>11</sup> While the spiritual care interventions did not primarily measure the Becker’s problems as outcomes

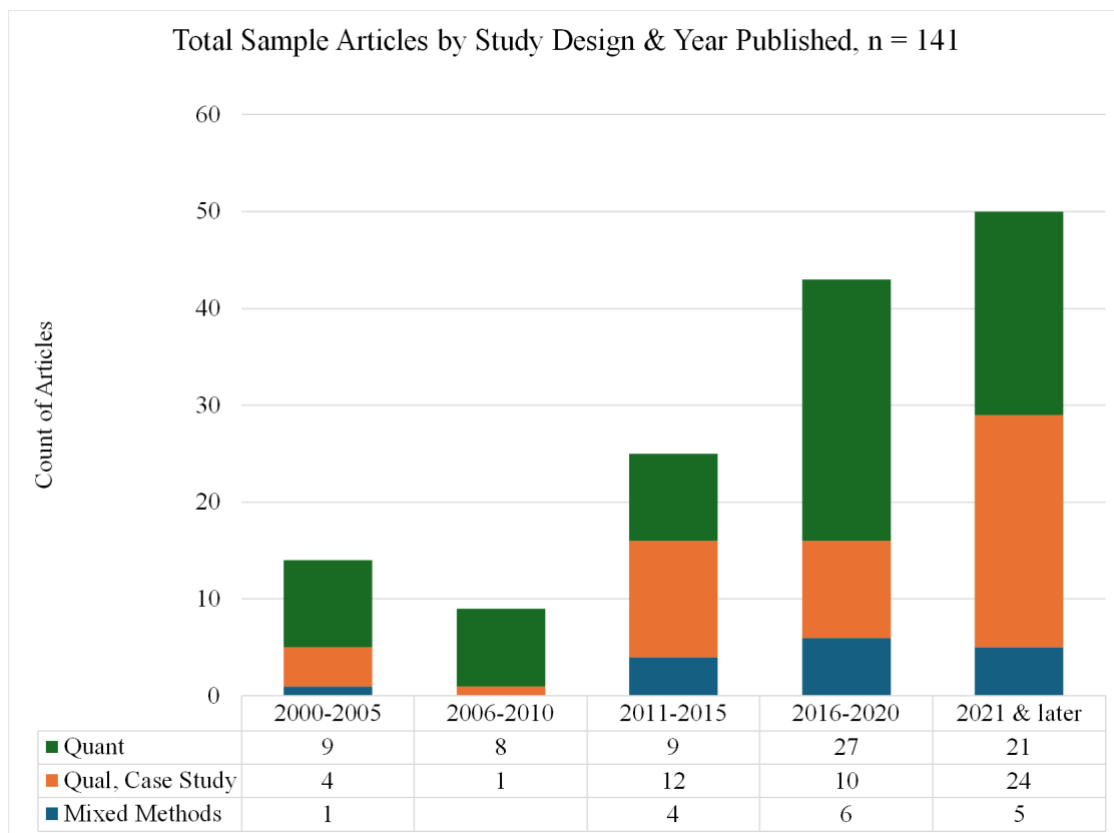
in the study, we matched them according to professional knowledge and expertise. Two team members, a spiritual care researcher with training in health services research (KW) and a healthcare management researcher (LM), worked collectively to assign a healthcare administration problem to each article and ensure agreement.

Articles that described general spiritual care were examined to consider the impact of SCPs’ care for a specific group of people (e.g., patients, family members). We extracted the details of how the study authors described the spiritual care provided in the article to further define “general spiritual care” and highlight the most common spiritual care activities in this body of literature.

### Results

Our final sample included 141 articles. A majority were quantitative (50.4%, n = 71), while 36.1% were qualitative or case study (n = 51), and 19 (13.5%) used mixed methods. The largest proportion were published in a spiritual care journal (24.8%, n = 35) or a palliative care journal (19.1%, n = 27). Most reported on spiritual care in a hospital setting (66.7%, n = 94) while 32 occurred in an outpatient setting (22.7%). Table 2 summarizes these article details. The number articles also rose over time (see Figure 2). Total Sample of Articles by Study Design & Year, n = 141.

Figure 2. Total Sample of Articles by Study Design & Year, n = 141



A total of 74 articles (52.5%) reported on an explicit intervention, 46 on general spiritual care (32.6%), and a final group of 21 articles (14.9%) explored the availability and utilization of spiritual care. We describe each of these three sets of articles in turn.

Table 2. Characteristics of articles, n = 141

Article Characteristic	N (Number)	N (Percent)
Study Design		
Quantitative	71	50.4%
Mixed Methods	19	13.5%
Qualitative	25	17.7%
Case Study	26	18.4%
Journal Discipline		
Chaplaincy	35	24.8%
Education	5	3.5%
Medicine & Surgery	17	12.1%
Nursing	11	7.8%
Oncology	7	5%
Palliative Care	27	19.1%
Psychology	1	0.7%
Public Health	4	2.8%
Religion & Health	21	14.9%
Other	13	9.2%
Target Population		
Patients	50	35.5%
Caregivers	21	14.9%
Clinicians	36	25.5%
Clinicians-in-Training	12	8.5%
Other	34	24.1%
Setting		
Hospital	96	68.1%
Outpatient / Clinic	43	30.5%
Skilled Nursing Facility	2	1.4%
Intervention		
Chaplain Only	94	66.7%
Interdisciplinary Intervention	9	6.4%
Combination	25	17.7%
Discussed Health Administrator Role?		
Yes	30	21.3%
No	111	78.7%

Year of Publication		
1998 – 2002	5	3.5%
2003 – 2007	11	7.8%
2008 – 2012	11	7.8%
2013 – 2017	43	30.5%
2018 – 2024	71	50.4%

### Connection Between Explicit Spiritual Care Interventions and Healthcare Challenges

Explicit spiritual care interventions present in the literature suggest that SCPs are specifically focused on problems related to workforce challenges, access to care, and patient experience and satisfaction (see Table 3 and Table 4). A small number of interventions also aligned with concerns for patient safety and quality. Interventions that focus on clinicians are described in Table 5 and interventions that focus on patients or caregivers are described in Table 6. Overall, we identified many different types of interventions with fourteen occurring in two or more research articles.

The most common intervention, spirituality groups and medical student shadowing, occurred in nine articles with the next most common – Code Blue Response and Telechaplancy – each occurring in five articles. While some of the differently named interventions may follow a shared or common underlying approach, parsing such possible commonalities was beyond the scope of this review. (Note: Some articles were grouped under multiple categories due to the complexity of the intervention.)

Table 3. Problems Faced by Healthcare Executives & SCP Interventions

Becker's Problem	No. of Studies	Interventions (number of studies <sup>a</sup> )	Intervention Rigor Range <sup>b</sup>
Access to Care	24	Caregiver Outlook (n = 1)	(4, 4)
		Guide Spiritual Struggles (GuideSS_CF) (n=1)	(3, 3)
		MESH Outpatient Program (n = 1)	(1, 1)
		MICAH HEAL Project (n = 2)	(0, 2)
		Moral Injury Groups (n = 2)	(0, 4)
		RISE Second Victim Support Program (n = 1)	(0, 0)
		Spiritual Care Advocate (n=1)	(4, 4)
		Spirituality Group (n = 9)	(0, 5)
		Telechaplancy (n = 5)	(0, 2)
		Warrior to Soul Mate (n = 1)	(3, 3)
Patient Safety & Quality	3	MICAH HEAL Project (n = 2)	(0, 2)
		Family Communication Coordinator (FCC) (n = 1)	(5, 5)
Patient Satisfaction & Experience	16	Dignity Therapy (n = 2)	(4, 5)
		Caregiver Outlook (n = 1)	(4, 4)

		Godly Play (n = 1)	(0, 0)
		Lectio Divina (n = 1)	(4, 4)
		Picture-guided Spiritual Care Communication Board (n=1)	(4, 4)
		Spiritual Legacy Intervention (n = 3)	(3, 5)
		SCAI (n = 2)	(5, 5)
		Spiritual AIM (n = 1)	(4, 4)
		Spiritual Coaching (n = 1)	(4, 4)
		This Is My Story (TIMS) (n = 3)	(0, 3)
		Visual Thinking Strategies (n = 1)	(1, 1)
Workforce Challenges	36	Call to Wellness (n = 1)	(4, 4)
		Center for Stress Resilience & Personal Growth (n = 1)	(3, 3)
		Code Blue Response (Post Code Pause, Family Facilitator) (n = 4)	(0, 4)
		Compassion-Centered Spiritual Health Team (n = 1)	(3, 3)
		Compassion Rounds (n = 1)	(1, 1)
		Family Communication Coordinator (FCC) (n = 4)	(3, 5)
		Finding Soul Work (n = 1)	(0, 0)
		Medical Student Shadowing / Education (n = 9)	(0, 4)
		Patient Navigator (n = 1)	(2, 2)
		Resiliency Bundle (n = 1)	(3, 3)
		Spiritual Generalist Workshop (n = 1)	(4, 4)
		Spiritual Meditation Program (n = 1)	(3, 3)
		Spiritual Needs of Nursing Program (n = 1)	(2, 2)
		Tea for the Soul, Chi Cart Ministry, Chi Time (n = 3)	(1, 2)
		Threshold A Capella Choir (n = 1)	(4, 4)
This is My Story (TIMS) (n = 3)	(0, 3)		

<sup>a</sup> Rigor Score interpretations: 0 case study; 1 qualitative; 2 cross-sectional, retrospective of existing data, or pilot/feasibility; 3 mixed methods; 4 pre / post, quasi experimental, or cohort study; 5 randomized control trial, experimental or longitudinal

<sup>b</sup> There may be more than one study that used that particular intervention; we associated the intervention with that problem when the outcome of the study was related to that specific problem. Interventions that appear more than one time in the literature may appear under multiple problems.

<sup>c</sup> One study (not included here) aimed to address financial challenges, but did not show a significant result.

Table 4. Interventions occurring at least twice in the literature by Problem and Rigor

Intervention	No. of Studies	Becker's Problem	Max Rigor Score <sup>a</sup>
Spirituality Groups	9	Access to Care	5
Medical Student Shadowing	9	Workforce Challenges	4
Telechaplancy	5	Access to Care	2
Code Blue Response (Family Facilitator, Post Code Pause, Family Support Person)	5	Workforce Challenges Patient Satisfaction & Experience	4
Family Communication Coordinator	4	Workforce Challenges Patient Safety & Quality	5
Spiritual Legacy Intervention	3	Patient Satisfaction & Experience	5
This is My Story (TIMS)	3	Patient Satisfaction & Experience Workforce Challenges	3
Tea for the Soul, Chi Cart Ministry, Chi Time	3	Workforce Challenges	2
Dignity Therapy	2	Patient Satisfaction & Experience	5
SCAI	2	Patient Satisfaction & Experience	5
MICAH HEAL Project	2	Access to Care	4
Mindfulness Meditation Group	2	Workforce Challenges	4
Spiritual AIM	2	Access to Care	4

<sup>a</sup> Rigor Score interpretations: 0 case study; 1 qualitative; 2 cross-sectional, retrospective of existing data, or pilot/feasibility; 3 mixed methods; 4 pre / post, quasi experimental, or cohort study; 5 randomized control trial, experimental or longitudinal

### **Workforce Interventions**

We grouped 36 articles under the topic of workforce interventions. The spiritual care interventions that focused on the clinical workforce typically fell into three categories (articles are not exclusive to one category): 1) interventions to address clinician burnout or stress (12 articles), 2) interventions that adapted workflow/clinical processes to improve stress (15 articles), and 3) interventions that aimed to improve workforce utilization of spiritual care resources (11 articles). Details of the articles that used interventions for clinicians is available in Appendix 3.

Many interventions were designed to help clinicians address burnout, stress, or emotional exhaustion experienced in the workplace. The Tea for the Soul intervention,<sup>30</sup> Chi Cart Ministry Programs,<sup>31,32</sup> and the Threshold Choir<sup>33</sup> which aimed to support clinicians spiritually and emotionally found positive associations with nurses' sense of peace, sense of support, and connection to professional purpose. The Spiritual Needs Nursing

Program, a form of interdisciplinary rounding, did not have an impact.<sup>34</sup> The case study written about the program Finding Soul Work helped clinicians connect to their larger purpose within an outpatient setting.<sup>35</sup> The Resiliency Bundle – an effort to teach about moral distress and resilience<sup>36</sup> – and the Spiritual Meditation Program<sup>37</sup> helped clinicians deal with trauma they encounter on a daily basis.

SCPs also developed approaches to care for colleagues not working in direct patient care roles. These interventions focused on hospital security officers,<sup>38</sup> Community Health Advisors,<sup>39</sup> and Clinical Research Coordinators.<sup>40</sup> While these studies primarily reported on feasibility and acceptability, three studies did report that clinicians had improved perspectives of burnout and resilience and felt they were more equipped to cope.<sup>38,40,41</sup> The Call to Wellness Intervention offered clinicians either an individual or group session with a SCP to discuss how to maintain spiritual and emotional resiliency in the workplace; clinicians reported an overall positive experience.<sup>42</sup>

Several interventions that adapted clinical process or workflow to improve clinician stress. One protocol aimed to improve communication regarding patients' spiritual concerns within documentation<sup>43</sup> and another focused on organ donation. The Family Communication Coordinator was designed to improve the organ donation and communication processes between caregivers, clinicians, and the external organ procurement organization.<sup>44–47</sup> This intervention was associated with lower levels of clinician stress and decreased role ambiguity.<sup>45,47</sup> Additional ways where SCPs were integrated into clinical processes included Code Blue Responses (Family Facilitator, Post Code Pause, Family Support Person),<sup>48–53</sup> This is my Story (TIMS),<sup>54–56</sup> and the Patient Care Navigator.<sup>57</sup> These efforts were used to decrease demand on clinicians by using the SCP as an additional resource. For code responses, SCPs became a liaison between family members and the clinical team or led the team in a post-death pause<sup>48–52</sup>; TIMS provided clinicians access to an auditory recording of the patient's story prior to hospital clinical rounding.<sup>54–56</sup> The Post Code Support Pause/Family Facilitator effort improved clinicians sense of support from their leaders and empowered them to return to work at their own pace.<sup>49,50</sup>

Finally, interventions that addressed workforce challenges focused on improving clinician knowledge of spiritual care or chaplains' roles through medical student shadowing. Six studies reported on the feasibility of shadowing.<sup>58–63</sup> All of these efforts improved clinicians' understanding of spiritual care as a resource. Two studies highlighted how shadowing influenced the importance and critical nature of communication skills<sup>61,63</sup> and others reported students' appreciation of the opportunity for personal introspection.<sup>58,59,61,62</sup> Compassion Rounds took a similar approach, but focused more on interdisciplinary communication and processing, for active clinicians (non-students).<sup>64</sup>

The Spiritual Generalist Training offered in one setting helped increase clinicians' comfort in referring to SCPs.<sup>65</sup> Finally, multiple studies reported on joint educational efforts between medical students and spiritual care students as a way to improve interdisciplinary collaboration. One case study reported on the feasibility of joint simulation activities<sup>66</sup> and others noted improved sense of collaboration and non-chaplain clinician self-awareness from joint education efforts.<sup>67,68</sup>

## **Access to Care Interventions**

A total of 24 articles were grouped under access to care. Interventions focused on access to care are in one of three broad categories (articles are not exclusive to one category): 1) spiritual care interventions that build connections between patients and a specific health system (9 articles), 2) outpatient interventions (13 articles), and 3) efforts to work directly with the community on health and wellbeing (4 articles). Details of the articles that used interventions for patients is available in Appendix 4 and caregivers in Appendix 5.

Interventions that built connections between patients, caregivers and health systems typically extended a level of spiritual attention through telehealth methods. For instance, five articles reported on the feasibility of telechaplancy and the ability to provide emotional/spiritual crisis support virtually or over the telephone. Three of those studies reported on the feasibility of integrating the intervention and patients' acceptance of the intervention by SCPs<sup>69,70</sup>; and one reported a higher prevalence of the practice by rural SCPs.<sup>71</sup> The remaining two used a case study methodology<sup>72,73</sup> and one highlighted how to use telechaplancy to integrate virtual spiritual care for a Medicare advantage population.<sup>72</sup> Programs like the Spiritual Care Advocate<sup>74</sup> or the Patient Navigation program<sup>75</sup> increased patients' perceptions of support from the clinical team by using a SCP as a liaison between spiritual communities and medical teams. The "GuideSS\_CF", an intervention aimed to address spiritual struggle for parents of children with Cystic Fibrosis delivered over the phone, was associated with lower levels of depression and improvements in positive spiritual coping for the parents.<sup>76</sup>

The majority of SCPs' outpatient interventions were spirituality groups, defined as SCP-led or SCP-co-led group discussion on spirituality related topics for patients or caregivers; seven studies used this modality for spiritual care.<sup>77-83</sup> These spirituality groups covered a wide range of topics and ultimately look more like proactive population health initiatives that aim to strengthen positive coping and psychosocial-spiritual support through a group style intervention. For example, articles with the most rigorous study design were able to demonstrate improvements in participants religious coping<sup>77-79</sup> and quality of life.<sup>81</sup> Similar interventions, such as meditation groups<sup>84</sup> or moral injury groups<sup>85-87</sup> have also been used to address psychosocial concerns. The most robustly designed studies showed an improvement in PTSD symptoms for veterans including reduced thoughts of suicidality and anxiety.<sup>84,86</sup> The Caregiver Outlook intervention focused on the care of family and friends who are providing care to those with life-limiting illness demonstrates a more proactive and psychosocial intervention.<sup>88</sup> SCPs worked directly with these caregivers to process self-care needs, how to cope with intense caregiving demands, and improve wellbeing in an outpatient setting. Finally, the MESH Outpatient Program integrated a SCP within a primary care clinic to see if a team approach could reduce unnecessary hospitalizations.<sup>89</sup> While the study design was exploratory, patients who visited with the SCP reported higher levels of trust, satisfaction with care, and improved coping.<sup>89</sup>

Finally, interventions such as the MICAHEAL project,<sup>39,90</sup> Warrior to Soul Mate (W2SM),<sup>41</sup> and the RISE Second Victim Support Program<sup>91</sup> took SCPs and their colleagues into the community where they provide targeted support for specific communities. While all exploratory in nature, these programs offer unique models to maximize on SCPs' skills. Both the MICAHEAL and W2SM programs aimed to help alleviate some tension in the

healthcare workforce process and mirrored traditional public health interventions. The MICAH Heal project used SCPs to train community health workers to partner with chaplains for health education<sup>39,90</sup> and the W2SM aimed to partner veterans with community members to address social isolation.<sup>41</sup> Finally, one case study demonstrated the feasibility of SCPs teaching clinicians to respond to secondary traumatic exposure.<sup>91</sup>

### ***Patient Experience and Satisfaction Interventions***

The third area of focus for spiritual care interventions fell under the broad umbrella of patient satisfaction, often called patient experience, with a total of 16 articles. We categorized articles based on outcomes related to whole-person or patient-centered care.

For instance, several articles reported associations between improved spiritual wellbeing and receipt of the spiritual care intervention (12 articles). Interventions such as the Spiritual Assessment & Intervention Model (Spiritual AIM),<sup>92,93</sup> Spiritual Coaching,<sup>94</sup> Visual Thinking Strategies,<sup>95</sup> and the Spiritual Care Assessment & Intervention (SCAI)<sup>96,97</sup> examined the impact of a formalized model of spiritual assessment/direct care to explore associations with patient religious coping and spiritual wellbeing. The Spiritual Aim, SCAI, and Spiritual Coaching interventions were successful in doing so. Four other interventions were designed to aid in a specific aspect of care. The Picture-guided Spiritual Care Communication Board enabled spiritual care to alert and ventilated patients and ultimately demonstrated a reduction in anxiety.<sup>98</sup> One team utilized the story-telling approach called “Godly Play” to engage pediatric patients in deeper discussion (case study).<sup>99</sup> The Lectio Divina intervention used a meditative reading for psychiatric patients and reduced spiritual injury scores.<sup>100</sup> While the “This is My Story (TIMS)” intervention was designed to communicate with clinicians, we also grouped this intervention under patient experience since it ultimately aims to humanize patients with audio recordings.<sup>54-56</sup> While the authors have not yet demonstrated impact, there is potential to do so.

We grouped together another set of spiritual care interventions that targeted those who were at or near end-of-life (5 articles). For example, the Spiritual Legacy Intervention, an intervention that aimed to document the legacy and stories of patients with advanced cancer to pass along to their families and loved ones, improved patients’ spiritual wellbeing, coping, and quality of life.<sup>101-103</sup> Dignity Therapy uses a similar method; implementation of that intervention (sometimes led by a SCP and sometimes led by a nurse) improved patients’ sense of dignity and articles demonstrated its affordability (approximately \$331 per patient).<sup>104,105</sup>

### ***Patient Safety & Quality Interventions***

Finally, we grouped several interventions previously discussed also under patient safety and quality (3 articles). Specifically, the MICAH HEAL project<sup>39,90</sup> and the Family Communication Coordinator.<sup>44-47</sup> which aim to improve communication between the care team and the patient seeking care – a vital component of safety in care delivery. The previous discussion of the Family Communication Coordinator highlighted how the intervention decreased stress and role ambiguity for clinicians during organ donation processes. While these studies did not

directly measure a safety or quality metric, the nature of the intervention as designed to improve communication, could be tied to safety and quality for death determination processes.

Table 5. SCP Intervention Descriptions (for Clinicians)

Intervention	Intervention Description	Study ID(s)
<b>Multiple Clinical Disciplines</b>		
Chi Time, Chi Cart Ministry, Tea for Soul	Mobile cart with tea, healthy snacks, music, words of comfort, and aromatherapy for staff stress reduction. Applies tenets of a Japanese tea ceremony to encourage group gathering	Keogh 2017 Keogh 2020 Callis 2022
Compassion Rounds	Rounds by a spiritual care clinician, physician, and other care providers that focus only on the emotional and spiritual well-being of the patient	McManus 2022
Family Support Person, Post Code Pause, Family Facilitator	Spiritual care clinicians support staff during resuscitation events. In one study, this manifested as a silent pause after a death to process and honor the death	Mureau-Haines 2017 Tennyson 2023 Teague 2019 Copeland 2016
Finding Soul Work	Group sessions that help employees reconnect to meaning in their work and provide an avenue for emotional/spiritual processing	King 2005
Resiliency Bundle	Program that helped clinicians through 1) teaching how to resolve ethical issues, 2) mindfulness reminders through cell phone app, 3) patient death support, 4) case conference discussions, 5) structured debriefings, 6) supporting discussions, 7) leadership notification, 8) social events, 9) educational courses, and 10) connecting employees with employee assistant program	Davis 2020
RISE Second Victim Support Program	RISE peer responder calls the clinician requesting support within 30 minutes and meeting within 12 hours and provides psychological first aid (focusing on emotions evoked rather than details on incident). Responder then connects employee to additional resources if needed	Edrees 2016
Spiritual Care Protocol	Protocol elements include staff training; screening, assessment, and reassessment of patients' spiritual needs; providing spiritual care	Smith 2022

	interventions based on the TRUST model; and documentation	
Spiritual Generalist Workshop	Workshop trains clinicians to identify spiritual needs through the use of spiritual screening, identifying and managing spiritual distress, and how to collaborate with spiritual care services	Bandini 2019
Spiritual Meditation Program	Mindfulness meditation for clinical staff and their spiritual wellbeing	Freeman 2020
This is My Story (TIMS)	Audio file of a patient's story and identity to help clinicians to learn more about them. Audio file was included in the electronic medical record	Tracey 2023
Threshold Choir	An a Capella choir sang on a unit to create an atmosphere of calm and peace while trying to elicit compassionate care	Catlin 2019
<b>Clinical research coordinators</b>		
Compassion-Centered Spiritual Health Team Intervention (CCSH-TI)	Spiritual care intervention that aimed to improve relationships, emotional intelligence, compassion, and positive coping strategies to improve teamwork. Sessions included group discussions, team building, and social connections	Mascaro 2021
<b>Community health advisors (CHA)</b>		
MICAH HEAL Project	Population health initiative where SCPs train and equip Community Health Advisors to work with community members and maximize health system resources.	Marin 2019 Marin 2022
<b>Nurses</b>		
Family Communication Coordinator (FCC)	The FCC spiritual care clinical role decreases stress and nurse role ambiguity by facilitating the communication between caregivers of potential organ donors and the organ procurement organization. The FCC spiritual care clinician facilitates communication, coordinates meetings, and monitors patients' cognitive functioning	Dodd-McCue 2005 Dodd-McCue 2024
Spiritual Needs Nursing Program	The program includes interdisciplinary rounds, a forum for nurses to confidentially process their concerns, family presence during resuscitation events, brief ethics consultations, and debriefing huddles	Campbell 2013

<b>Clinicians-in-training</b>		
Call to Wellness	Spiritual care clinician served as a resource for physician-trainees. They could schedule a one-on-one session with a spiritual care clinician or attend a group meeting. The sessions allowed clinicians to discuss personal stressors and wellbeing needs	Shapiro 2019
End-of-Life Training	Interdisciplinary training on how to guide parents of sick children by applying approaches to spiritual care. Also includes training on guided questioning and dynamic team roles of caregivers.	Wada 2019
Medical Ethics Education	Ethics training program for medical students. Curriculum includes student shadowing spiritual care clinicians, lectures, discussion, and mentoring in medical ethics.	Sullivan 2020
Medical Student / Resident Shadowing and Education	Trainees spend time shadowing spiritual care clinicians to understand their role, the importance of spiritual care, learn emotional intelligence, and how to approach spiritual issues with patients.	Hemming 2016a Hemming 2016b Perechocky 2014 Frazier 2015 Suda 2023 Gomez 2020 DeFoor 2021

Table 6. SCP Interventions (patients & caregivers)

<b>Intervention</b>	<b>Intervention Description</b>	<b>Associated Studies</b>
<b>Patients</b>		
Building Spiritual Strength Group Intervention	Spirituality Group that focuses on the resolution of spiritual distress exacerbated by PTSD symptoms. The group is either led by a mental health clinician qualified to provide spiritual care or spiritual care clinician	Harris 2018
Patient Navigator	Spiritual care clinician (Patient Navigator) PN is assigned to a patient / caregiver within 24 hours of admittance to an ICU. The PN provides advocacy, schedules interdisciplinary meetings, answers caregiver questions, provides emotional and spiritual support, and connects patients / caregivers to community resources	Alghanim 2021
Dignity Therapy	Psychotherapeutic interview intervention that produces a legacy document for patients' caregivers. The intervention	Al Yacoub 2023 Wilkie 2024

	aims to provide spiritual comfort through verbal processing of their story, find meaning in their illness, and create a legacy document for their family	
Godly Play	Formally created for Biblical story-telling to children in churches. The approach has been adapted for use by spiritual care clinicians. They share a story accompanied by a two- or three-dimensional artefact and initiate wondering with verbal rhetorical questions. The audience responds via any modality they prefer: art, journaling, conversation, and concluded by group processing	Minor 2016
Lectio Divina	Ritual-like service with 4 steps: <i>lectio</i> (focused reading), <i>meditatio</i> (meditation), <i>oratio</i> (prayer), and <i>contemplatio</i> (contemplation)	Kopacz 2017
MESH Outpatient Program	Population health initiative focused on increasing communication between individuals and their providers and reducing barriers to care. The spiritual care clinician identifies and addresses spiritual needs and facilitates / encourages communication with health care team	Sadras 2024
Mindfulness Meditation Group	Spiritual Care Clinician guided group meditation using scripted guiding comments	Blum 2021
Moral Injury (MI) Group	Group intervention facilitated by both a spiritual care clinician and a psychologist. The facilitated group therapy sessions follow guidelines from the <i>Trauma and Recovery</i> or REAL curriculum.	Franco 2023 Smigelsky 2022
Picture Guided Spiritual Care Communication Board	Spiritual care communication card helps spiritual care clinician assess alert non-verbal patients identify spiritual needs. Patients can point to pictures and words from four sections that reflect areas of spiritual assessment. Includes illustrated emotions to aid in emotional distress evaluation	Berning 2016
Spiritual AIM	Proposes that every person has three core spiritual needs: for meaning and direction, to love and be loved, and for self-worth and belonging to community. Focuses on relationships and healing in relationships. Chaplain assesses patients' spiritual needs, then chooses corresponding intervention	Kestenbaum 2017
Spiritual Coaching	Assessment of patient's understanding of their spiritual self. Exploring activities which foster connection to the outside world. Coach acts as an ally in seeking what patient finds meaningful, then aids them in increasing participation in those activities or exploring new ones. During follow-up,	Levy 2006

	coach assesses success of practiced spiritual activity and develops strategy for expanding patient's spiritual life	
Spiritual Legacy Intervention	A comprehensive, chaplain-led spiritual life review process that includes a spiritual legacy interview and development of a personalized spiritual legacy document for patients. The document acts as a way to pass down their important life stories to the important people in their lives	Piderman 2015 Piderman 2017 Piderman 2020
Spirituality Group	Group sessions using discussions of various spiritual topics or approaches such as Sacred Story or peer support programs. In some versions, the spiritual care clinician may also use a deck of cards, patients describe their belief of how God feels about them and what they would have to do for God to feel glad about them	Boehm 2020 Grossoehme 2001 Kidd 2001 Wing Yee Wong 2019 Rummans 2006
Telechaplancy	Spiritual care clinicians deliver interventions by video conference or phone to patients who report religious/spiritual need during screening	Sprick 2021
This is My Story (TIMS)	A short summary of a patient's identify / story that is uploaded to the patient's medical records to aid in personalization of care. Medical providers, nurses and other team members can listen to the short recording as a way of personalizing their care	Tracey 2021 Wilson 2023
Visual Thinking with Artwork	During a spiritual care session, patient is asked to sort images into two: the ones they like and those they do not like. The patient then selects and discusses one of the images. The spiritual care clinician will then ask questions about the image to help with meaning-making	Gelo 2015
Warrior to Soul Mate (W2SM)	The program teaches interpersonal skills and how to sustain close relationships by pairing a veteran with another person. They attend sessions that last 6 – 10 weeks and learn communication skills, conflict resolution, and self-awareness	Fortune-Britt 2015
<b>Caregivers</b>		
Caregiver Outlook	Spiritual care clinician leads three sessions with a patient's caregiver to discuss their life relationship with the patient, unaddressed relational or forgiveness issues, and lessons learned and future goals. The caregiver received a handout after each session that captured their discussion. Spiritual care follow-up check-in sessions also occurred following the third session	Steinhauser 2016

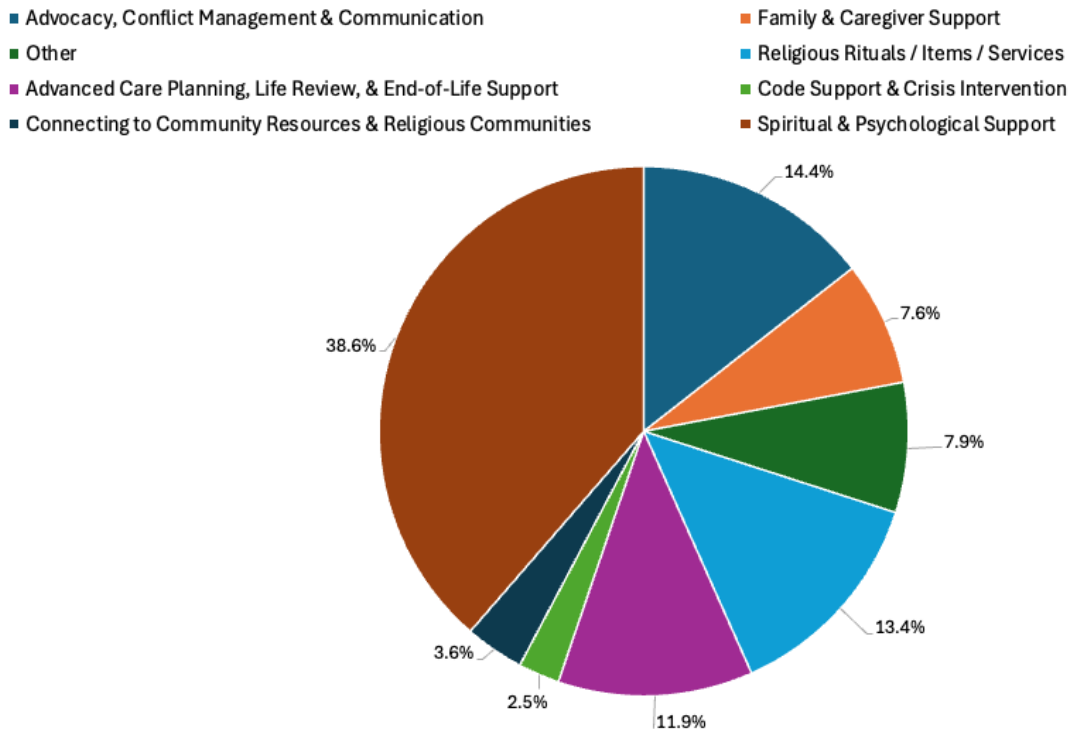
Compassion Rounds	Rounds by a chaplain, physician, and other care providers that focus only on the emotional and spiritual well-being of the patient	McManus 2022
Family Communication Coordinator (FCC)	The FCC spiritual care clinician manages communication between caregivers of potential organ donors and the organ procurement organization. This includes navigating complex relational dynamics and monitoring reports of patients' cognitive status	Tartaglia 2000
Family Support Person	Assists and supports a patient's family when present for resuscitation	Clark 2005
GuideSS_CF	An intervention to help parents of children with Cystic Fibrosis deal with spiritual struggles through three semi-structured, telephone-based spiritual care interventions. Sessions focus on divine struggle and meaning-making	Betz 2019
Peer Support Program (THRIVE)	Support group co-lead by a social worker and spiritual care clinician to help patients and caregivers process ICU memories and recovery. Groups also included a nurse to help with specific medical processing	Boehm 2000
Spiritual Care Assessment & Intervention (SCAI)	Semi-structured framework with guidelines on spiritual assessment (4 dimensions), 26 interventions, and documentation of spiritual care. Addresses 4 key dimensions: Meaning and Purpose, Relationships, Transcendence and Peace, and Self-Worth and Identity	Perez 2022 Torke 2023
Spiritual Legacy Intervention	A comprehensive, spiritual care clinician-led life review process that includes a spiritual legacy interview and development of a personalized spiritual legacy document for patients and their caregivers	Piderman 2017

## Connection Between General Spiritual Care and Healthcare Challenges

In addition to research articles focused on explicit approaches to offering spiritual care, we identified 46 articles in the scoping review that reported on what we called general spiritual care activities.

Figure 3. Activities Included in General Spiritual Care (n=231) as Percent of all Observed (46 Articles)

Activities Included in General Spiritual Care (n=231) as Percent of all Observed (46 Articles)



Articles that described general spiritual care were examined to extract the details of how the study authors described the spiritual care provided in the article to further define “general spiritual care.” Figure 3 summarizes those activities into themes to further understand general spiritual care and describe the empirical evidence for its impact on four sets of outcomes. We were able to categorize SCP’s activities into Appendices 6 and 7 summarize the studies that report on general spiritual care.

### Benefits of General Spiritual Care for Workforce Challenges

The impact of general spiritual care on workforce challenges is evident in two primary ways. First, multiple articles discussed SCPs role in interdisciplinary collaboration.<sup>128-132</sup> The authors demonstrated both the acceptability and feasibility of including SCPs in interdisciplinary collaborations and suggested this integration results in de-siloed care approaches. Further, when palliative care medical directors were asked, 86% believed that including SCPs on clinical teams strengthened their ability to address spiritual suffering, navigate communication, and support clinical team members.<sup>133</sup> Pediatric physicians noted that SCPs helped clinicians and parents navigate the pediatric dying process.<sup>134</sup>

Second, the literature is abundant with examples of how SCPs promote improved understanding and education about spiritual health. Several articles noted how SCPs taught clinician colleagues about spirituality as a core identity in one's health and wellbeing, how to identify spiritual struggle, and when to refer patients for professional spiritual care support.<sup>65,134-136</sup> Finally, multiple articles described what SCPs mean when they discuss providing staff support or staff care. For example, SCPs will adapt or create formal rituals to give space for coping or debriefing.<sup>137</sup> Other articles described how SCPs provide empathetic listening, encouragement for deeper conversation, discussion of spiritual needs, and encourage wellbeing.<sup>107,135,136,138</sup> This care, per chaplain report, appears to take around 30% of their time in some places and upwards of 60% in other systems.<sup>139</sup> While researchers are just beginning to explore the impact of specific activities on clinician stress, one study did demonstrate an association between more interaction with a SCP and lower levels of perceived stress.<sup>140</sup>

### ***Benefits of General Spiritual Care for Access to Care Challenges***

Studies that explored the impact of general spiritual care on access to care or health service, had mixed findings. One exploratory case study, reported on the feasibility and acceptability of spiritual care for children with medical complexity in an outpatient setting.<sup>147</sup> In another outpatient study, patients with advanced diseases who received multidisciplinary interventions, including chaplain support, used fewer health services.<sup>110</sup> Other studies have attempted to demonstrate a connection between spiritual care and length of stay.<sup>106,148</sup> One study, with a fairly robust design, found an association between those receiving spiritual care and shorter hospital stays,<sup>106</sup> while the other observed longer stays.<sup>148</sup> However, the latter study noted a trend of shorter lengths of stay if SCPs visited within the first 48 hours of admission.<sup>148</sup> Similarly related, another pilot project integrated a SCP in an immigrant outpatient clinic as a way for the health system to provide whole-person care and identified that many patients experienced a lot of feelings of grief and abandonment.<sup>149</sup> While explored in a few cases, empirical connections between general spiritual care and access to care remains limitedly in the literature.

### ***Benefits of General Spiritual Care for Patient Experience and Satisfaction Challenges***

Most of the studies that described general spiritual care approaches aligned with efforts to improve patient experience and satisfaction. Three studies indicated a positive link between general spiritual care and improved patient experience.<sup>106-108</sup> Specifically, these articles highlighted the benefits of spiritual care in enhancing positive religious coping,<sup>109</sup> spiritual well-being, and quality of life.<sup>110,111</sup> One study found lower depression levels in patients receiving care from SCPs with greater compassion and influence.<sup>112</sup> Descriptive or exploratory studies that engaged patients demonstrated that spiritual care services are wanted for more than just religious functions – spiritual care clinicians provide emotional, spiritual, and medical decision-making support. In one study, 45% of patients indicated moderate to severe spiritual concerns<sup>113</sup> and upwards of 70% reported wanting to speak to a spiritual care clinician in another study.<sup>114</sup> While many patients may request a blessing or prayer,<sup>115</sup> patients reported appreciating SCPs for the ability to form relationships,<sup>116</sup> their extensive emotional, spiritual, and decision-making support,<sup>117-120</sup> and in one case ability to aid in pain management.<sup>121</sup> SCPs described the importance of their work in a similar way and further emphasized the benefit of their emotional availability, ability to establish rapport, and discuss deeper meaning-making issues.<sup>122</sup>

Many of these efforts demonstrated an influence on caregiver experience. One study reported that neonatal intensive care unit (NICU) caregivers reported higher satisfaction with hospital care when receiving spiritual care.<sup>123</sup> Caregivers also had higher levels of satisfaction with chaplains when they received emotional, religious support, or guidance during medical decision making.<sup>118,124</sup> Multiple studies also highlighted caregivers' desire for bereavement care, such as calls, memorial services, and ongoing chaplain support, especially following complex deaths.<sup>125-127</sup>

### ***Benefits of General Spiritual Care for Patient Safety and Quality Challenges***

General spiritual care also includes activities around advanced care planning, improving communication, and assisting with ethical consultations. SCPs often play a central role in navigating communication between patients, caregivers, and the medical team.<sup>133,138,141,142</sup> Depending on the patient and family's comfort or trust with the health system, the SCP may become the only person with whom they can trust to discuss personal, but related, concerns. While patients/families frequently desired this support, 45% of SCPs in one survey reported they were not always included in healthcare team discussions about care planning.<sup>143</sup> This becomes increasingly important for ethics consultations and helping clinicians navigate ethical dilemmas and conflict that arises out of medical decision making.<sup>144</sup> Several studies indicated that chaplain involvement improved perceptions of communication.<sup>64,123,145</sup> When religious concerns impact medical decision making, SCPs' ability to navigate complex communications was valuable.<sup>146</sup> In addition, patients also appreciated the ability to discuss practical concerns with spiritual care clinicians.<sup>117</sup>

### **Availability and Utilization of Spiritual Care Services**

The final group of articles (21 articles) we reviewed reported on how available spiritual care services are in U.S. health systems, described the perceptions of healthcare executives, or reported on a scope of responsibilities or components of spiritual care.

Studies gauged the perception of SCPs, from multiple perspectives. When hospital administrators and directors were interviewed, they reported believing that the most important spiritual care services revolved around grief and death care, emotional support, and chaplains functioning as community liaisons.<sup>150,151</sup> The general public and hospitalized patients also mentioned specific expectations of SCPs. More young adults wanted spiritual care than received it in one instance<sup>152</sup> while those not hospitalized and members of the general public focused on the religious aspects of their care.<sup>153</sup> These articles also reported that hospital executives who operated hospitals without spiritual care departments rated chaplain functions as less important than those with a department.

Several mapping studies described the scope of spiritual services in various settings. As previously discussed, the approaches taken by SCPs in these studies is summarized in Figure 3. These efforts have occurred in palliative care,<sup>154</sup> the top performing acute care hospitals,<sup>155-158</sup> pediatric hospitals,<sup>159</sup> specific spiritual care provided in the intensive care unit,<sup>160</sup> and specific hospitals like the New York City Hospitals.<sup>161</sup> The later team

described several cases of how to shift some of a system's spiritual care resources to an outpatient setting<sup>162</sup> and added to an existing 2012 case of outpatient spiritual care.<sup>163</sup> In Chicago in 2010, the Catholic member hospitals also assessed the scope of their services.<sup>164</sup>

Other articles describe more nuanced approaches taken to spiritual care or care for a very specific population. For example, one study that reported on the unique integration of music-related interventions.<sup>165</sup> Another reported the aspects of spiritual care when integrating a SCP in psychedelic assisted therapy.<sup>166</sup> Two articles reported on the difference in spiritual care provision between Muslim and non-Muslim SCPs as well as director's impressions of Muslim SCPs. Those studies noted the additional layer of support Muslim SCPs provide when directly caring for Muslim patients.<sup>167,168</sup> Another team described SCPs abilities and training that equips them to provide care for Veterans at risk for suicide<sup>169</sup> and another spoke to the unique spiritual needs of burn patients.<sup>170</sup>

As a group, the articles in this section suggest that hospitals utilizing general spiritual care typically benefit in these key areas. Integrating SCPs means that their training and skills are helping in such areas as workforce challenges, access to care, and patient experience. While many studies do not directly measure these things, the outcomes they do measure are linked elsewhere.

## Discussion

Healthcare executives face increasing demands to navigate workforce challenges, demands to improve patients' experience and satisfaction, and barriers in community members' access to care. This scoping literature review connected the strategies employed by SCPs and their interventions to these challenges to identify the potential for an innovative collaboration between SCPs and executives. Interventions led by SCPs most frequently aid in some aspect of workforce wellbeing, access to care, and patient experience. Even general spiritual care, as defined here by the range of SCP integration, could add resources to deal with those challenges. We suggest that spiritual care providers are an underutilized resource that when integrated fully could maximizing organizational goals.

Spiritual care interventions for clinical workforce typically address clinician burnout, stress, or improve utilization of spiritual care resources through explicit and general approaches to spiritual care. The explicit interventions that demonstrate the most significant positive results include the Tea for the Soul and Chi Cart Ministry Programs which improve wellbeing and for recipients and an increase sense of support from administrative leaders. Studies that integrated a SCP into how inpatient facilities respond to Code Blues, specifically when working with patients' family or friends as well as the Pause for clinicians, show great promise in truly aiding workforce wellbeing. Efforts to improve clinician knowledge of spiritual care through medical student shadowing programs and joint educational initiatives demonstrated great promise for the incoming workforce; we believe such shadowing could benefit interdisciplinary collaboration and communication for other disciplines. For instance, a healthcare executive may be able to co-develop additional innovative integrations of SCPs if they had exposure to such shadowing programs.

Spiritual care interventions that connect to an aspect of access to care, the accessibility of health services, or extend the reach of the healthcare system also offer great promise in building trust with the external community. Researchers have documented additional efforts to promote community health, led by chaplains, that appear beyond this literature review.<sup>171</sup> Based on our review, Telechaplancy, outpatient spirituality groups, and the MICAH HEAL project offer the most promising avenues to include SCPs in addressing access to care. Evidence suggests that SCPs are much more integrated in (or leading) community-based programs than evidenced in our review and could provide additional space for innovation. SCPs' skills align well with public health efforts as does the fact that many SCPs see correspondence with the local community as part of their core responsibilities.<sup>155</sup> Overall, these interventions offer great promise for addressing access to care challenges and community health and wellbeing.

Efforts to enhance patient experience can directly affect healthcare organizations' financial reimbursements. We find the Spiritual Care Assessment & Intervention (SCAI) model, Dignity Therapy, and the Spiritual Legacy Intervention most promising in this regard. These approaches incorporate patients' narratives into care planning and honoring them as whole individuals. Although two of these interventions target individuals with chronic or terminal illnesses, who may not participate in satisfaction surveys, additional evidence should be considered. Specifically, researchers now emphasize that all chronic or terminal patients should receive spiritual care as a core aspect of their treatment because it can impact health outcomes.<sup>6</sup> Additionally, the strongest evidence for the impact of spiritual care on patient experience actually arises from the studies that examined general spiritual care. Future research or quality improvement efforts should integrate a patient experience measurement, as seen in general spiritual care literature, with these robust interventions.

## Limitations

The present report is the most thorough examination of the alignment between spiritual care and the challenges within healthcare delivery. A few limitations are worth noting. First, scoping review methodology surveys the landscape of a specific topic within published literature. It does not aim to create generalizable information and can only provide a general overview of a topic. Second, most of the articles in the final sample for the literature review did not explicitly utilize measures of workforce wellbeing, access to care, or patient experience. We believe that using two researchers to categorize interventions according, especially given their training in health services research and management, helped mitigate bias but did not eliminate it. Finally, the body of evidence that identifies the efficacy and importance of spiritual care is emerging and a limited number used experimental designs or targeted outcome measures. We believe this presents an ideal opportunity for spiritual care researchers, SCPs, and partnerships with healthcare executives.

## Conclusions

The existing literature suggests the potential for innovation in utilizing SCPs' unique skillsets and spiritual care interventions to address some of the most perplexing problems in healthcare management. Existing interventions as well as general spiritual care suggests SCPs could add extra support to addressing workforce

challenges, access to care challenges, and improving patient experience and satisfaction. Healthcare executives consistently find themselves struggling to attend to these problems and prioritize their improvements as they ultimately influence an organization's operational stability. SCPs could offer innovative solution if integrated fully.

## References

1. Massey K, Barnes MJD, Villines D, et al. What do I do? Developing a taxonomy of chaplaincy activities and interventions for spiritual care in intensive care unit palliative care. *BMC Palliat Care*. 2015;14:10. doi:10.1186/s12904-015-0008-0
2. Cadge W. *Paging God: Religion in the Halls of Medicine*. University of Chicago Press; 2012. <https://press.uchicago.edu/ucp/books/book/chicago/P/bo13963369.html>
3. Cadge W, Freese J, Christakis N. Hospital Chaplaincy in the United States: A National Overview. *South Med J*. 2008;101(6):626-630.
4. Fitchett G, White KB, Lyndes K. *Evidence-Based Healthcare Chaplaincy: A Research Reader*. Jessica Kingsley Publishers; 2018.
5. Puchalski CM, Vitillo R, Hull SK, Reller N. Improving the spiritual dimension of whole person care: reaching national and international consensus. *J Palliat Med*. 2014;17(6):642-656. doi:10.1089/jpm.2014.9427
6. Balboni TA, VanderWeele TJ, Doan-Soares SD, et al. Spirituality in serious illness and health. *JAMA*. 2022;328(2):184-197. doi:10.1001/jama.2022.11086
7. Long KNG, Symons X, VanderWeele TJ, et al. Spirituality as a determinant of health: emerging policies, practices, and systems: article examines spirituality as a social determinant of health. *Health Aff (Millwood)*. 2024;43(6):783-790. doi:10.1377/hlthaff.2023.01643
8. Lawton A, Cadge W, Hamar Martinez J. How does the American public interact with chaplains? Evidence from a national survey. *J Health Care Chaplain*. 2024;30(2):137-151. doi:10.1080/08854726.2023.2239109
9. Antoine A, Fitchett G, Marin D, et al. What organizational and business models underlie the provision of spiritual care in healthcare organizations? An initial description and analysis. *J Health Care Chaplain*. 2022;28(2):272-284. doi:10.1080/08854726.2020.1861535
10. Antoine A, Fitchett G, Sharma V, et al. How do healthcare executives understand and make decisions about spiritual care provision? *South Med J*. 2021;114(4):207-212. doi:10.14423/SMJ.0000000000001230
11. Gooch, K. The No. 1 problem still keeping hospital CEOs up at night. *Becker's Hospital Review*. <https://www.beckershospitalreview.com/hospital-management-administration/the-no-1-problem-still-keeping-hospital-ceos-up-at-night.html>. January 31, 2024. Accessed February 5, 2024.
12. American College of Healthcare Executives. *Survey: Workforce Challenges Cited by CEOs as Top Issue Confronting Hospitals in 2022*. American College of Healthcare Executives; 2023. <https://www.ache.org/about-ache/news-and-awards/news-releases/survey-workforce-challenges-cited-by-ceos-as-top-issue-confronting-hospitals-in-2022am>

13. Delaney RK, Locke A, Pershing ML, et al. Experiences of a health system's faculty, staff, and trainees' career development, work culture, and childcare needs during the COVID-19 pandemic. *JAMA Netw Open*. 2021;4(4):e213997. doi:10.1001/jamanetworkopen.2021.3997
14. Weidman AJ. Establishing a sustainable healthcare delivery workforce in the wake of COVID-19. *J Healthc Manag*. 2022;67(4):234-243. doi:10.1097/JHM-D-22-00100
15. Kominski, G.F., Nonzee, N.J., Sorensen, A. The affordable care act's impacts on access to insurance and health care for low-income populations. *Annu Rev Public Health*. 2017;38:489-505. doi:10.1146/annurev-publhealth-031816-044555
16. Oyeka, O., Ullrich, F., Shane, D., Mueller, K.J. Changes in service offerings post-system affiliation in rural hospitals. *RUPRI Cent Rural Health Policy Anal*. 2023(2). <https://rupri.public-health.uiowa.edu/publications/policybriefs/2023/Hospital%20System%20Participation%20and%20Services.pdf>
17. Whitacre BE, Rhoades CA, Davis AF. Rural hospital service lines: changes over time and impacts on profitability. *J Healthc Manag*. 2024;69(5):350-367. doi:10.1097/JHM-D-24-00012
18. Mazurenko O, Collum T, Ferdinand A, Menachemi N. Predictors of hospital patient satisfaction as measured by HCAHPS: a systematic review. *J Healthc Manag*. 2017;62(4):272-283. doi:10.1097/JHM-D-15-00050
19. Doyle C, Lennox L, Bell D. A systematic review of evidence on the links between patient experience and clinical safety and effectiveness. *BMJ Open*. 2013;3(1):e001570. doi:10.1136/bmjopen-2012-001570
20. Marin DB, Sharma V, Sosunov E, Egorova N, Goldstein R, Handzo GF. Relationship between chaplain visits and patient satisfaction. *J Health Care Chaplain*. 2015;21(1):14-24. doi:10.1080/08854726.2014.981417
21. White, Kelsey B., McClelland, Laura, Jennings, J'Aime C., Karimi, Seyed, Fitchett, George. The impact of chaplaincy departments on hospital patient experience scores. *J Healthc Manag*. Published online March 2025. doi:[Accepted for Publication]
22. Tricco AC, Lillie E, Zarin W, et al. PRISMA extension for scoping reviews (PRISMA-ScR): checklist and explanation. *Ann Intern Med*. 2018;169(7):467-473. doi:10.7326/M18-0850
23. Damen A, Schuhmann C, Leget C, Fitchett G. Can outcome research respect the integrity of chaplaincy? A review of outcome studies. *J Health Care Chaplain*. 2020;26(4):131-158. doi:10.1080/08854726.2019.1599258
24. Sprik PJ, Vanderstelt H, Valenti-Hein C, Denton J, Ashton D. Chaplain interventions and outcomes in outpatient settings: a scoping review. *J Health Care Chaplain*. 2024;30(4):306-328. doi:10.1080/08854726.2024.2357042

25. Knapp S, Schaefer B, Stratton RG, Usset TJ, K Yadav S, Fitchett G. Chaplain care for health care colleagues: a scoping review. *J Health Care Chaplain*. Published online October 21, 2024:1-30. doi:10.1080/08854726.2024.2386872
26. Carey LB, Hodgson TJ, Krikheli L, et al. Moral injury, spiritual care and the role of chaplains: an exploratory scoping review of literature and resources. *J Relig Health*. 2016;55(4):1218-1245. doi:10.1007/s10943-016-0231-x
27. O'Connor TStJ. The search for truth: the case for evidence-based chaplaincy. *J Health Care Chaplain*. 2002;13(1):185-194. doi:10.1300/J080v13n01\_03
28. Fitchett G. Recent progress in chaplaincy-related research. *J Pastor Care Couns*. 2017;71(3):163-175. doi:10.1177/1542305017724811
29. Portney, L.G., Watkins, M.P. *Foundations of Clinical Research: Applications to Evidence-Based Practice*. 3rd ed. F.A. Davis; 2015.
30. Callis A, Cacciata M, Wickman M, Choi J. An effective in-hospital chaplaincy-led care program for nurses: Tea for the soul a qualitative investigation. *J Health Care Chaplain*. 2022;28(4):526-539. doi:10.1080/08854726.2021.1932134
31. Keogh M, Marin DB, Jandorf L, Wetmore JB, Sharma V. Chi Time: expanding a novel approach for hospital employee engagement. *Nurs Manag (Harrow)*. 2020;51(4):32-38. doi:10.1097/01.NUMA.0000654852.18136.d7
32. Keogh M, Sharma V, Myerson SL, Marin DB. The Chi Cart ministry. *Nurs Manag (Harrow)*. 2017;48(8):32-38. doi:10.1097/01.NUMA.0000521574.35431.50
33. Catlin A, Cobbina M, Dougherty R, Laws D. Music, Spirituality, and caring science: the effect of a cappella song on healthcare staff in medical-surgical units. *Int J Hum Caring*. 2019;23(3):234-241. doi:10.20467/1091-5710.23.3.234
34. Campbell D. Spirituality, stress, and retention of nurses in critical care. *Dimens Crit Care Nurs*. 2013;32(2):78-83. doi:10.1097/DCC.0b013e31828083a4
35. King S, Jarvis D, Cornwell M. Programmatic staff care in an outpatient setting. *J Pastor Care Couns*. 2005;59(3):263-273. doi:10.1177/154230500505900309
36. Davis M, Batcheller J. Managing moral distress in the workplace: creating a resiliency bundle. *Nurse Lead*. 2020;18(6):604-608. doi:10.1016/j.mnl.2020.06.007

37. Freeman R, Sukuan N, Tota N, Bell S, Harris A, Wang H. Promoting spiritual healing by stress reduction through meditation for employees at a veterans hospital: a CDC framework-based program evaluation. *Workplace Health Saf.* 2020;68(4):161-170. doi:10.1177/2165079919874795
38. Costello Z, Roberson-Miranda K, Ho S, et al. A resilience program for hospital security officers during the COVID-19 pandemic using a community engagement model. *J Community Health.* 2023;48(6):963-969. doi:10.1007/s10900-023-01282-w
39. Marin D, Karol A, Sharma V, et al. MICAH Project HEAL: sustainability of a faith-based community health advisor training program in urban underserved communities in the USA. *J Relig Health.* 2022;61(3):2527-2538. doi:10.1007/s10943-021-01453-w
40. Mascaro JS, Palmer PK, Ash MJ, et al. Feasibility, Acceptability, and Preliminary Effectiveness of a Compassion-Centered Team Intervention to Improve Clinical Research Coordinator Resilience and Well-Being. *JCO Oncol Pr.* 2021;17(7):e936-e946. doi:10.1200/OP.21.00120
41. Fortune-Britt AG, Nieuwsma JA, Gierisch JM, et al. Evaluating the Implementation and Sustainability of a Program for Enhancing Veterans' Intimate Relationships. *Mil Med.* 2015;180(6):676-683. doi:10.7205/MILMED-D-14-00336
42. Shapiro RE, Vallejo MC, Sofka SH, Elmo RM, Anderson AH, Ferrari ND. Hospital Spiritual Care Can Complement Graduate Medical Trainee Well-Being. *Adv Med.* 2019;2019:8749351-8749351. doi:10.1155/2019/8749351
43. Smith C, Lakin T. Effects of an Interprofessional Spiritual Care Education Project. *J Hosp Palliat Nurs.* 2022;24(1):78-83. doi:10.1097/NJH.0000000000000819
44. Dodd-McCue D, Tartaglia A. The Impact of the Family Communication Coordinator (FCC) Protocol on the Role Stress of Hospital Chaplains. *J Pastor Care Couns.* 2005;59(4):345-360. doi:10.1177/154230500505900404
45. Dodd-McCue D, Tartaglia A, Veazey KW, Streetman PS. The Impact of Protocol on Nurses' Role Stress: A Longitudinal Perspective. *J Nurs Adm.* 2005;35(4):205-216. doi:10.1097/00005110-200504000-00010
46. Tartaglia A, Linyear AS. Organ donation: a pastoral care model. *J Pastoral Care.* 2000;54(3):277-286. doi:10.1177/002234090005400305
47. Dodd-McCue, Diane, Tartaglia, Alexander, Myer, Kevin, Kuthy, Susan, Faulkner, Ken. Unintended Consequences: The Impact of Protocol Change on Critical Care Nurses' Perceptions of Stress. *Prog Transplant.* 2004;14(1):61-67. doi:10.1177/152692480401400110
48. Clark AP, Aldridge MD, Guzzeta CE, et al. Family presence during cardiopulmonary resuscitation. *Crit Care Nurs Clin North Am.* 2005;17(1):23-32.

49. Copeland D. Implementation of a Post-Code Pause. *J Trauma Nurs.* 2016;23(2):58-64. doi:10.1097/JTN.000000000000187
50. Mureau-Haines R, Boes-Rossi M, Casperson S, et al. Family Support During Resuscitation: A Quality Improvement Initiative. *Crit Care Nurse.* 2017;37(6):14-23. doi:10.4037/ccn2017347
51. Tennyson C, Oliver J, Jooste K. Developing a Decision Pathway for Family Presence During Resuscitation. *Dimens Crit Care Nurs.* 2023;42(3):163-170. doi:10.1097/DCC.0000000000000577
52. Tennyson C, Oliver J, Jooste K. A descriptive study of chaplains' code blue responses. *Am J Crit Care.* 2021;30(6):419-425. doi:10.4037/ajcc2021854
53. McWhirter M, Heikkinen P, Derisse G, Mehta A. Specialty Palliative Care in a Code Blue: An Unexpected Role. *J Palliat Med.* 2022;25(11):1747-1750. doi:10.1089/jpm.2021.0617
54. Tracey E, Crowe T, Wilson J, Ponnala J, Rodriguez-Hobbs J, Teague P. An Introduction to a Novel Intervention, "This is My Story", to Support Interdisciplinary Medical Teams Delivering Care to Non-Communicative Patients. *J Relig Health.* 2021;60(5):3282-3290. doi:10.1007/s10943-021-01379-3
55. Tracey E, Wilson J, Saylor M, et al. TIMS: A Mixed Methods Evaluation of the Impact of a Novel Chaplain Facilitated Recorded Interview Placed in the Medical Chart for the Medical Staff in an ICU During the COVID-19 Pandemic. *J Relig Health.* 2023;62(3):1532-1545. doi:10.1007/s10943-023-01800-z
56. Wilson J, Tracey E, Ponnala J, Rodriguez-Hobbs J, Crowe T. An ICU Expansion of a Novel Chaplain Intervention, "This is My Story," to Support Interdisciplinary Medical Teams Delivering Care to Non-Communicative Patients in an Academic Medical Center. *J Relig Health.* 2023;62(1):83-97. doi:10.1007/s10943-022-01567-9
57. Alghanim F, Furqan M, Prichett L, et al. The effect of chaplain patient navigators and multidisciplinary family meetings on patient outcomes in the ICU: the Critical Care Collaboration and Communication Project. *Crit Care Explor.* 2021;3(11).
58. DeFoor M, Moses M, Flowers W, Sams R. Medical student reflections: Chaplain shadowing as a model for compassionate care training. *Med Teach.* 2021;43(1):101-107. doi:10.1080/0142159X.2020.1817880
59. Frazier M, Schnell K, Baillie S, Stuber M. Chaplain Rounds: A Chance for Medical Students to Reflect on Spirituality in Patient-Centered Care. *Acad PSYCHIATRY.* 2015;39(3):320-323. doi:10.1007/s40596-015-0292-2
60. Gomez S, White B, Browning J, DeLisser H. Medical Students' Experience in a Trauma Chaplain Shadowing Program: A Mixed Method Analysis. *Med Educ Online.* 2020;25(1). doi:10.1080/10872981.2019.1710896

61. Perechocky A, DeLisser H, Ciampa R, Browning J, Shea J, Corcoran A. Piloting a Medical Student Observational Experience With Hospital-Based Trauma Chaplains. *J Surg Educ.* 2014;71(1):91-95. doi:10.1016/j.jsurg.2013.07.001
62. Suda S, Burkbauer L, White B, Browning J, DeLisser H. Medical Students' Reflections on Their Experiences in a Trauma Chaplain Shadowing Program. *Am J Hosp Palliat Med.* 2023;40(10):1124-1131. doi:10.1177/10499091221149192
63. Hemming P, Teague P, Crowe T, Levine R. Chaplains on the Medical Team: A Qualitative Analysis of an Interprofessional Curriculum for Internal Medicine Residents and Chaplain Interns. *J Relig Health.* 2016;55(2):560-571. doi:10.1007/s10943-015-0158-7
64. McManus K, Robinson P. A thematic analysis of the effects of compassion rounds on clinicians and the families of NICU patients. *J Health Care Chaplain.* 2022;28(1):69-80. doi:10.1080/08854726.2020.1745489
65. Bandini J, Thiel M, Meyer E, Paasche-Orlow S, Zhang Q, Cadge W. Interprofessional Spiritual Care Training for Geriatric Care Providers. *J Palliat Med.* 2019;22(10):1236-1242. doi:10.1089/jpm.2018.0616
66. Wada RK, Wong L, Flohr A, et al. Engaging a Community Chaplaincy Resource for Interprofessional Health Care Provider Training in Facilitating Family Decision Making for Children at End-of-Life. *Hawaii J Med Public Health J Asia Pac Med Public Health.* 2019;78(6 Suppl 1):37-40.
67. Hemming P, Teague P, Crowe T, Levine RB. Demystifying Spiritual Care: An Interprofessional Approach for Teaching Residents and Hospital Chaplains to Work Together. *J Grad Med Educ.* 2016;8(3):454-455. doi:10.4300/JGME-D-15-00637.1
68. Sullivan B, DeFoor M, Hwang B, Flowers W, Strong W. A Novel Peer-Directed Curriculum to Enhance Medical Ethics Training for Medical Students: A Single-Institution Experience. *J Med Educ Curric Dev.* 2020;7. doi:10.1177/2382120519899148
69. Sprik P, Keenan A, Boselli D, Cheeseboro S, Meadors P, Grosseohme D. Feasibility and acceptability of a telephone-based chaplaincy intervention in a large, outpatient oncology center. *Support Care Cancer.* 2021;29(3):1275-1285. doi:10.1007/s00520-020-05598-4
70. Sprik P, Walsh K, Boselli D, Meadors P. Using patient-reported religious/spiritual concerns to identify patients who accept chaplain interventions in an outpatient oncology setting. *Support Care Cancer.* 2019;27(5):1861-1869. doi:10.1007/s00520-018-4447-z
71. Sprik P, Keenan A, Boselli D, Grosseohme D. Chaplains and telechaplaincy: best practices, strengths, weaknesses-a national study. *J Health Care Chaplain.* 2023;29(1):41-63. doi:10.1080/08854726.2022.2026103

72. Valenti-Hein C. Integrating Spiritual Care in Population Health and Care Management Two Case Examples. *Prof Case Manag.* 2022;27(5):229-238. doi:10.1097/NCM.0000000000000564
73. Winiger F. The changing face of spiritual care: current developments in telechaplaincy. *J Health Care Chaplain.* 2023;29(1):114-131. doi:10.1080/08854726.2022.2040895
74. Cipriano-Steffens T, Cursio J, Hlubocky F, et al. Improving End of Life Cancer Outcomes Through Development and Implementation of a Spiritual Care Advocate Program. *Am J Hosp Palliat Med.* 2021;38(12):1441-1450. doi:10.1177/1049909121995413
75. Teague P, Kraeuter S, York S, Scott W, Furqan M, Zakaria S. The Role of the Chaplain as a Patient Navigator and Advocate for Patients in the Intensive Care Unit: One Academic Medical Center's Experience. *J Relig Health.* 2019;58(5):1833-1846. doi:10.1007/s10943-019-00865-z
76. Betz J, Szczesniak R, Lewis K, et al. Feasibility and Acceptability of a Telephone-Based Chaplaincy Intervention to Decrease Parental Spiritual Struggle. *J Relig Health.* 2019;58(6):2065-2085. doi:10.1007/s10943-019-00921-8
77. Boehm LM, Drumright K, Gervasio R, Hill C, Reed N. Implementation of a Patient and Family-Centered Intensive Care Unit Peer Support Program at a Veterans Affairs Hospital. *Crit Care Nurs Clin North Am.* 2020;32(2):203-210. doi:10.1016/j.cnc.2020.02.003
78. Grosseohme DH. Self-reported value of spiritual issues among adolescent psychiatric inpatients. *J Pastoral Care.* 2001;55(2):139-145. doi:10.1177/002234090105500203
79. Harris J, Usset T, Voecks C, Thuras P, Currier J, Erbes C. Spiritually integrated care for PTSD: A randomized controlled trial of "Building Spiritual Strength." *Psychiatry Res.* 2018;267:420-428. doi:10.1016/j.psychres.2018.06.045
80. Kidd RA, Maripolsky V, Smith PP. The use of sacred story in a psychiatry spirituality group. *J Pastoral Care.* 2001;55(4):353-364. doi:10.1177/002234090105500402
81. Rummans TA, Clark MM, Sloan JA, et al. Impacting Quality of Life for Patients with Advanced Cancer With a Structured Multidisciplinary Intervention: A Randomized Controlled Trial. *JCO.* 2006;24(4):635-642. doi:10.1200/JCO.2006.06.209
82. Timbers V, Childers M. A case study in group spiritual care for residents of a post-acute care facility. *J Relig Spiritual Aging.* 2021;33(1):86-96. doi:10.1080/15528030.2020.1822262
83. Wing Yee Wong, Bunn A, Ramprasad S. Spirituality and Aging Support Groups: A Psycho-Spiritual Intervention to Address the Mental Health Needs of Older Adults. *Ann Long-Term Care.* 2019;27(6):e13-e18. doi:10.25270/altc.2019.04.00068

84. Blum H, Rutt C, Nash C, Joyce V, Buonopane R. Mindfulness Meditation and Anxiety in Adolescents on an Inpatient Psychiatric Unit. *J Health Care Chaplain*. 2021;27(2):65-83. doi:10.1080/08854726.2019.1603918
85. Franco Z, Antal C, Yeomans P, et al. Transforming Veteran Identity Through Community Engagement: A Chaplain-Psychologist Collaboration to Address Moral Injury. *J Humanist Psychol*. 2023;63(6):801-826. doi:10.1177/0022167819844071
86. Smigelsky M, Malott J, Parker R, Check C, Rappaport B, Ward S. Let's Get "REAL": A Collaborative Group Therapy for Moral injury. *J Health Care Chaplain*. 2022;28:S42-S56. doi:10.1080/08854726.2022.2032978
87. Fleming W. The Moral Injury Experience Wheel: An Instrument for Identifying Moral Emotions and Conceptualizing the Mechanisms of Moral Injury. *J Relig Health*. 2023;62(1):194-227. doi:10.1007/s10943-022-01676-5
88. Steinhauer K, Olsen A, Johnson K, et al. The feasibility and acceptability of a chaplain-led intervention for caregivers of seriously ill patients: A Caregiver Outlook pilot study. *Palliat Support Care*. 2016;14(5):456-467. doi:10.1017/S1478951515001248
89. Sadras V, Carrese JA, Fitz A, Gatti MLE, Teague P. Exploring Patients' and Chaplains' Perspectives About a Spiritual Care Program in the Primary Care Setting. *J Gen Intern Med*. Published online 2024. doi:10.1007/s11606-024-08669-y
90. Marin D, Costello Z, Sharma V, Knott C, Lam D, Jandorf L. Adapting Health through Early Awareness and Learning Program into a New Faith-Based Organization Context. *Prog Community Health Partnersh-Res Educ Action*. 2019;13(3):321-329. doi:10.1353/cpr.2019.0059
91. Edrees H, Connors C, Paine L, Norvell M, Taylor H, Wu AW. Implementing the RISE second victim support programme at the Johns Hopkins Hospital: a case study. *BMJ Open*. 2016;6(9):e011708. doi:10.1136/bmjopen-2016-011708
92. Kestenbaum A, James J, Morgan S, et al. "Taking your place at the table": an autoethnographic study of chaplains' participation on an interdisciplinary research team. *BMC Palliat Care*. 2015;14. doi:10.1186/s12904-015-0006-2
93. Kestenbaum A, Shields M, James J, et al. What Impact Do Chaplains Have? A Pilot Study of Spiritual AIM for Advanced Cancer Patients in Outpatient Palliative Care. *J Pain Symptom Manage*. 2017;54(5):707-714. doi:10.1016/j.jpainsymman.2017.07.027
94. Levy RD, Chan J. Spiritual coaching in cancer patients: treating the spirit as well as the disease. *J Pastor Care Couns*. 2006;60(4):395-404.
95. Gelo F, Klassen A, Gracely E. Patient use of images of artworks to promote conversation and enhance coping with hospitalization. *Arts Health*. 2015;7(1):42-53. doi:10.1080/17533015.2014.961492

96. Perez S, Maiko S, Burke E, et al. Spiritual Care Assessment and Intervention (SCAI) for Adult Outpatients With Advanced Cancer and Caregivers: A Pilot Trial to Assess Feasibility, Acceptability, and Preliminary Effects. *Am J Hosp Palliat Med*. 2022;39(8):895-906. doi:10.1177/104990912111042860
97. Torke A, Varner-Perez S, Burke E, et al. Effects of Spiritual Care on Well-Being of Intensive Care Family Surrogates: A Clinical Trial. *J Pain Symptom Manage*. 2023;65(4):296-307. doi:10.1016/j.jpainsymman.2022.12.007
98. Berning J, Poor A, Buckley S, et al. A Novel Picture Guide to Improve Spiritual Care and Reduce Anxiety in Mechanically Ventilated Adults in the Intensive Care Unit. *Ann Am Thorac Soc*. 2016;13(8):1333-1342. doi:10.1513/AnnalsATS.201512-831OC
99. Minor C, Campbell R. The Parable of the Sower: a case study examining the use of the Godly Play® method as a spiritual intervention on a psychiatric unit of a major children's hospital. *Int J Child Spiritual*. 2016;21(1):38-51. doi:10.1080/1364436X.2016.1150813
100. Kopacz MS, Adams MS, Searle RF. Lectio Divina: A Preliminary Evaluation of a Chaplaincy Program. *J Health Care Chaplain*. 2017;23(3):87-97. doi:10.1080/08854726.2016.1253263
101. Piderman KM, Breitkopf CR, Jenkins SM, et al. A Chaplain-led Spiritual Life Review Pilot Study for Patients with Brain Cancers and Other Degenerative Neurologic Diseases. *Rambam Maimonides Med J*. 2015;6(2):e0015-e0015. doi:10.5041/RMMJ.10199
102. Piderman KM, Radecki Breitkopf C, Jenkins SM, et al. The impact of a spiritual legacy intervention in patients with brain cancers and other neurologic illnesses and their support persons. *Psychooncology*. 2017;26(3):346-353. doi:10.1002/pon.4031
103. Piderman KM, Radecki Breitkopf C, Jenkins SM, et al. Hearing and Heeding the Voices of those With Advanced Illnesses. *J Palliat Care*. 2020;35(4):248-255. doi:10.1177/0825859720928623
104. Al Yacoub R, Rangel A, Shum-Jimenez A, et al. Cost considerations for implementing dignity therapy in palliative care: Insights and implications. *Palliat Support Care*. Published online 2023. doi:10.1017/S1478951523001177
105. Wilkie DJ, Fitchett G, Yao Y, et al. Engaging Mortality: Effective Implementation of Dignity Therapy. *J Palliat Med*. 2024;27(1):176-184. doi:10.1089/jpm.2023.0336
106. Heikkinen P, Roberts B. I see you: a Chaplain case study on existential distress and transdisciplinary support. *J Health Care Chaplain*. 2023;29(4):381-398. doi:10.1080/08854726.2022.2097780
107. Kao L, Lokko H, Gallivan K, O'Brien V, Peteet J. A Model of Collaborative Spiritual and Psychiatric Care of Oncology Patients. *Psychosomatics*. 2017;58(6):614-623. doi:10.1016/j.psych.2017.06.004

108. Wittenberg-Lyles E, Oliver D, Demiris G, Baldwin P, Regehr K. Communication Dynamics in Hospice Teams: Understanding the Role of the Chaplain in Interdisciplinary Team Collaboration. *J Palliat Med.* 2008;11(10):1330-1335. doi:10.1089/jpm.2008.0165
109. Kearney G, Fischer L, Groninger H. Integrating Spiritual Care into Palliative Consultation: A Case Study in Expanded Practice. *J Relig Health.* 2017;56(6):2308-2316. doi:10.1007/s10943-017-0419-8
110. Crane JR. A case study using the Discipline with a clinical team. *J Health Care Chaplain.* 2001;10(2):57-68. doi:10.1300/j080v10n02\_04
111. Fitchett G, Lyndes K, Cadge W, Berlinger N, Flanagan E, Misasi J. The Role of Professional Chaplains on Pediatric Palliative Care Teams: Perspectives from Physicians and Chaplains. *J Palliat Med.* 2011;14(6):704-707. doi:10.1089/jpm.2010.0523
112. Cadge W, Calle K, Dillinger J. What Do Chaplains Contribute to Large Academic Hospitals? The Perspectives of Pediatric Physicians and Chaplains. *J Relig Health.* 2011;50(2):300-312. doi:10.1007/s10943-011-9474-8
113. Taylor J, Hodgson J, Kolobova I, Lamson A, Sira N, Musick D. Exploring the Phenomenon of Spiritual Care Between Hospital Chaplains and Hospital Based Healthcare Providers. *J Health Care Chaplain.* 2015;21(3):91-107. doi:10.1080/08854726.2015.1015302
114. Kyoung-hae Kim, Bauck A, Monroe A, Mallory M, Aslakson R. Critical Care Nurses' Perceptions of and Experiences with Chaplains. *J Hosp Palliat Nurs.* 2017;19(1):41-48. doi:10.1097/NJH.0000000000000303
115. Klitzman R, Al-Hashimi J, Natarelli G, Garbuzova E, Sinnappan S. How hospital chaplains develop and use rituals to address medical staff distress. *SSM-Qual Res Health.* 2022;2. doi:10.1016/j.ssmqr.2022.100087
116. Nichols S. Examining the impact of spiritual care in long-term care. *Omega-J Death Dying.* 2013;67(1-2):175-184. doi:10.2190/OM.67.1-2.u
117. Nedjat-Haiem F, Carrion I, Gonzalez K, Ell K, Thompson B, Mishra S. Exploring Health Care Providers' Views About Initiating End-of-Life Care Communication. *Am J Hosp Palliat Med.* 2017;34(4):308-317. doi:10.1177/1049909115627773
118. Tartaglia A, White K, Corson T, et al. Supporting staff: The role of health care chaplains. *J Health Care Chaplain.* 2024;30(1):60-73. doi:10.1080/08854726.2022.2154107
119. Liberman T, Kozikowski A, Carney M, et al. Knowledge, Attitudes, and Interactions with Chaplains and Nursing Staff Outcomes: A Survey Study. *J Relig Health.* 2020;59(5):2308-2322. doi:10.1007/s10943-020-01037-0

120. Brand E, Shaw M, Galo J. Implementing Spiritual Care in the Pediatric Complex Care Clinic. *J Pastor Care Couns.* 2023;77(1):27-33. doi:10.1177/15423050221124038
121. Rabow MW, Dibble SL, Pantilat SZ, McPhee SJ. The Comprehensive Care Team: A Controlled Trial of Outpatient Palliative Medicine Consultation. *Arch Intern Med.* 2004;164(1):83. doi:10.1001/archinte.164.1.83
122. Iler WL, Obenshain D, Camac M. The Impact of Daily Visits from Chaplains on Patients with Chronic Obstructive Pulmonary Disease (COPD): A Pilot Study. *Chaplain Today.* 2001;17(1):5-11. doi:10.1080/10999183.2001.10767153
123. Labuschagne D, Torke A, Grosseohme D, et al. Chaplaincy Care in the MICU: Examining the Association Between Spiritual Care and End-of-Life Outcomes. *Am J Hosp Palliat Med.* 2021;38(12):1409-1416. doi:10.1177/1049909120987218
124. Kimball S, Syeda H, Chergui H, Piwowarczyk L, Gould J. Embedding Chaplaincy Services in Primary Care for Immigrants, Refugees and Asylum Seekers: A Boston Pilot Intervention. *J Relig Health.* 2023;62(1):55-64. doi:10.1007/s10943-022-01568-8
125. Sharma V, Marin D, Sosunov E, Ozbay F, Goldstein R, Handzo G. The Differential Effects of Chaplain Interventions on Patient Satisfaction. *J Health Care Chaplain.* 2016;22(3):85-101. doi:10.1080/08854726.2015.1133203
126. Bay PS, Beckman D, Trippi J, Gunderman R, Terry C. The Effect of Pastoral Care Services on Anxiety, Depression, Hope, Religious Coping, and Religious Problem-Solving Styles: A Randomized Controlled Study. *J Relig Health.* 2008;47(1):57-69.
127. Tadwalkar R, Udeoji D, Weiner R, et al. The Beneficial Role of Spiritual Counseling in Heart Failure Patients. *J Relig Health.* 2014;53(5):1575-1585. doi:10.1007/s10943-014-9853-z
128. Mascaro JS, Palmer PK, Willson M, et al. The Language of Compassion: Hospital Chaplains' Compassion Capacity Reduces Patient Depression via Other-Oriented, Inclusive Language. *Mindfulness.* 2023;14(10):2485-2498. doi:10.1007/s12671-022-01907-6
129. Muehlhausen B, Chappelle C, Delaney A, Peacock D, Stratton R, Fitchett G. Providing spiritual care to cancer patients in the outpatient context: a pilot study. *J Health Care Chaplain.* Published online 2023. doi:10.1080/08854726.2023.2266303
130. Piderman K, Marek D, Jenkins S, et al. Predicting Patients' Expectations of Hospital Chaplains: A Multisite Survey. *Mayo Clin Proc.* 2010;85(11):1002-1010. doi:10.4065/mcp.2010.0168

131. Hirschmann J, Kozato A, Sharma V, et al. An Analysis of Chaplains' Narrative Chart Notes Describing Spiritual Care Visits with Gender Affirmation Surgical Patients. *Transgender Health*. 2022;7(1):92-100. doi:10.1089/trgh.2020.0030
132. McCormick S, Hildebrand A. A Qualitative Study of Patient and Family Perceptions of Chaplain Presence During Post-Trauma Care. *J Health Care Chaplain*. 2015;21(2):60-75. doi:10.1080/08854726.2015.1016317
133. Idler E, Grant G, Quest T, Binney Z, Perkins M. Practical Matters and Ultimate Concerns, "Doing," and "Being": A Diary Study of the Chaplain's Role in the Care of the Seriously Ill in an Urban Acute Care Hospital. *J Sci Study Relig*. 2015;54(4):722-738. doi:10.1111/jssr.12235
134. Muehlhausen B, Foster T, Smith A, Fitchett G. Patients' and Loved Ones' Expectations of Chaplain Services. *J Health CARE Chaplain*. 2022;28(3):350-364. doi:10.1080/08854726.2021.1903734
135. Nageswaran S, Banks Q, Golden S, Gower W, King N. The role of religion and spirituality in caregiver decision-making about tracheostomy for children with medical complexity. *J Health Care Chaplain*. 2022;28(1):95-107. doi:10.1080/08854726.2020.1755812
136. King S, Jarvis D, Schlosser-Hall A. A Model for Outpatient Care. *J Pastor CARE Couns*. 2006;60(1-2):95-107. doi:10.1177/154230500606000110
137. Evans CB, Larimore LR, Grasmick VE. Hospital Chaplains, Spirituality, and Pain Management: A Qualitative Study. *Pain Manag Nurs*. 2024;25(1):75-79. doi:10.1016/j.pmn.2023.11.004
138. Chang B, Stein N, Skarf L. Spiritual distress of military veterans at the end of life. *Palliat Support Care*. 2015;13(3):635-639. doi:10.1017/S1478951514000273
139. Donohue P, Norvell M, Boss R, et al. Hospital Chaplains: Through the Eyes of Parents of Hospitalized Children. *J Palliat Med*. 2017;20(12):1352-1358. doi:10.1089/jpm.2016.0547
140. Johnson J, Engelberg R, Nielsen E, et al. The Association of Spiritual Care Providers' Activities With Family Members' Satisfaction With Care After a Death in the ICU. *Crit Care Med*. 2014;42(9):1991-2000. doi:10.1097/CCM.0000000000000412
141. Banyasz A, Weiskittle R, Lorenz A, Goodman L, Wells-Di Gregorio S. Bereavement Service Preferences of Surviving Family Members: Variation among Next of Kin with Depression and Complicated Grief. *J Palliat Med*. 2017;20(10):1091-1097. doi:10.1089/jpm.2016.0235
142. Cullen I, Bailes M, Shropshire P, Perry S, Karlekar M. Connecting Families to Bereavement Resources: A Hospital-Based, Bereavement Follow-Up Pilot During First-Wave COVID-19. *J Palliat Med*. Published online 2024. doi:10.1089/jpm.2023.0375

143. Thienprayoon R, Campbell R, Winick N. Attitudes and Practices in the Bereavement Care Offered by Children's Hospitals: A Survey of the Pediatric Chaplains Network. *Omega-J Death Dying*. 2015;71(1):48-59. doi:10.1177/0030222814568287
144. Cunningham C, Panda M, Lambert J, Daniel G, DeMars K. Perceptions of Chaplains' Value and Impact Within Hospital Care Teams. *J Relig Health*. 2017;56(4):1231-1247. doi:10.1007/s10943-017-0418-9
145. Flannelly K, Weaver A, Handzo G. A three-year study of chaplains' professional activities at Memorial Sloan-Kettering Cancer Center in New York City. *Psychooncology*. 2003;12(8):760-768. doi:10.1002/pon.700
146. Kwak J, Cho S, Handzo G, Hughes B, Hasan S, Luu A. The Role and Activities of Board-Certified Chaplains in Advance Care Planning. *Am J Hosp Palliat Med*. 2021;38(12):1495-1502. doi:10.1177/1049909121989996
147. Wirpsa M, Johnson R, Bieler J, et al. Interprofessional Models for Shared Decision Making: The Role of the Health Care Chaplain. *J Health Care Chaplain*. 2019;25(1):20-44. doi:10.1080/08854726.2018.1501131
148. Michelson K, Patel R, Haber-Barker N, Emanuel L, Frader J. End-of-Life Care Decisions in the PICU: Roles Professionals Play. *Pediatr Crit Care Med*. 2013;14(1):E34-E44. doi:10.1097/PCC.0b013e31826e7408
149. Bandini J, Courtwright A, Zollfrank A, Robinson E, Cadge W. The role of religious beliefs in ethics committee consultations for conflict over life-sustaining treatment. *J Med Ethics*. 2017;43(6):353-358. doi:10.1136/medethics-2016-103930
150. Flannelly KJ, Galek K, Bucchino J, Handzo GF, Tannenbaum HP. Department directors' perceptions of the roles and functions of hospital chaplains: a national survey. *Hosp Top*. 2005;83(4):19-27. doi:10.3200/htps.83.4.19-28
151. Flannelly K, Handzo G, Weaver A, Smith W. A National Survey of Health Care Administrators' Views on the Importance of Various Chaplain Roles. *J Pastor Care Couns*. 2005;59(1-2):87-96. doi:10.1177/154230500505900109
152. Piderman K, Jenkins S, Hsu J, Kindred A. Hospitalized Young Adults' Expectations of Pastoral Interventions. *J Pastor Care Couns*. 2013;67(1).
153. Lawton A, Cadge W. The content and effects of interactions with chaplains. *Palliat Support Care*. Published online 2023. doi:10.1017/S1478951523000597
154. Jeuland J, Fitchett G, Schulman-Green D, Kapo J. Chaplains Working in Palliative Care: Who They Are and What They Do. *J Palliat Med*. 2017;20(5):502-508. doi:10.1089/jpm.2016.0308
155. Tartaglia A, Corson T, White K, et al. Chaplain staffing and scope of service: benchmarking spiritual care departments. *J Health Care Chaplain*. 2024;30(1):1-18. doi:10.1080/08854726.2022.2121579

156. Montonye M, Calderone S. Pastoral Interventions and the Influence of Self-Reporting: A Preliminary Analysis. *J Health Care Chaplain*. 2009;16(1-2):65-73. doi:10.1080/08854720903519976
157. Risk JL. Building a new life: a chaplain's theory based case study of chronic illness. *J Health Care Chaplain*. 2013;19(3):81-98. doi:10.1080/08854726.2013.806117
158. Shu C. "I need my granddaughter to know who I am!" A case study of a 67-year-old African American man and his spiritual legacy. *J Health Care Chaplain*. 2023;29(3):256-268. doi:10.1080/08854726.2023.2209463
159. Lion A, Skiles J, Watson B, Young J, Torke A. Chaplain care in pediatric oncology: Insight for interprofessional collaboration. *Pediatr Blood Cancer*. 2019;66(12). doi:10.1002/pbc.27971
160. McCurry I, Jennett P, Oh J, White B, DeLisser H. Chaplain Care in the Intensive Care Unit at the End of Life: A Qualitative Analysis. *Palliat Med Rep*. 2021;2(1):280-286. doi:10.1089/pmr.2021.0012
161. Handzo GF, Flannelly KJ, Kudler T, et al. What do chaplains really do? II. Interventions in the New York Chaplaincy Study. *J Health Care Chaplain*. 2008;14(1):39-56. doi:10.1080/08854720802053853
162. Handzo G, Hughes B, Bowden J, et al. Chaplaincy in the outpatient setting-getting from here to there. *J Health CARE Chaplain*. 2022;28(2):194-207. doi:10.1080/08854726.2020.1818359
163. King S. Facing Fears and Counting Blessings: A Case Study of a Chaplain's Faithful Companionship of a Cancer Patient. *J Health Care Chaplain*. 2012;18(1-2):3-22. doi:10.1080/08854726.2012.667315
164. Guinan P, Zabiega T, Zainer C. Pastoral Care The Chicago Study. *Lincare Q*. 2010;77(2):175-180. doi:10.1179/002436310803888763
165. Klein CM. A survey of the use of music by hospice chaplains: a call for collaboration. *J Health Care Chaplain*. 2022;28(2):218-238. doi:10.1080/08854726.2020.1861532
166. Peacock C, Mascaro J, Brauer E, et al. Spiritual health practitioners' contributions to psychedelic assisted therapy: A qualitative analysis. *PLOS ONE*. 2024;19(1). doi:10.1371/journal.pone.0296071
167. Abu-Ras W. Muslim Chaplain's Role as Perceived by Directors and Chaplains of New York City Hospitals and Health Care Settings. *J MUSLIM Ment Health*. 2011;6(1):21-43.
168. Abu-Ras W, Laird L. How Muslim and Non-Muslim Chaplains Serve Muslim Patients? Does the Interfaith Chaplaincy Model have Room for Muslims' Experiences? *J Relig Health*. 2011;50(1):46-61. doi:10.1007/s10943-010-9357-4
169. Kopacz M. Providing Pastoral Care Services in a Clinical Setting to Veterans At-Risk of Suicide. *J Relig Health*. 2013;52(3):759-767. doi:10.1007/s10943-013-9693-2

170. Hultman C, Saou M, Roach S, et al. To Heal and Restore Broken Bodies A Retrospective, Descriptive Study of the Role and Impact of Pastoral Care in the Treatment of Patients With Burn Injury. *Ann Plast Surg.* 2014;72(3):289-294. doi:10.1097/SAP.000000000000087
171. White KB, Galchutt P, Collier K, Szilagyi C, Fitchett G. Chaplains' reports of integration in community health initiatives: a qualitative study. *J Health Care Chaplain.* Published online September 18, 2024:1-20. doi:10.1080/08854726.2024.2401742

## Appendices

### Appendix 1

#### Team Member Profiles & Advisory Council Profiles

##### Project Leadership Team



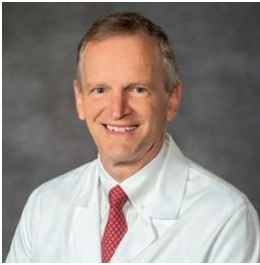
**Marilyn J.D. Barnes**  
**Chair for the Department of Patient Counseling**  
**College of Health Professions**  
**Virginia Commonwealth University**  
**Director of the Spiritual Care Department**  
**VCU Health**

Marilyn J. D. Barnes MS, MA, MPH, BCC is the Chair for the Department of Patient Counseling in the College of Health Professions at Virginia Commonwealth University (VCU) and the Director of the Spiritual Care Department at VCU Health System. She has presented at numerous conferences and her publications include the seminal chaplaincy research, “What do I do? Developing a taxonomy of chaplaincy activities and interventions for spiritual care in intensive care unit palliative care,” (*BMC Palliative Care*, 2015) which developed a normative language for chaplains and is currently being incorporated into chaplaincy practice in a variety of settings in the US and around the world, “Symbols of Comfort for a Journey of Grief,” (*Illness Crisis and Loss*, 2014) an article focused on the use of ritual during the initial grieving process, and “Spiritual Care Encounter – Journeying with a Grief Stricken Family” (*Simulation in Health: Journal of the Society for Simulation in Healthcare*, 2017). In 2022 she was a guest editor for the *Journal of Health Care Chaplaincy’s* special issue which focused on the experiences and impact of chaplains of color. She is a Board Certified Chaplain through the Association of Professional Chaplains.



**Wendy Cadge**  
**President and Professor, Bryn Mawr College**  
**Chaplaincy Innovation Lab Founder**

Wendy Cadge is the President of Bryn Mawr College and Professor of Sociology. She is an expert in contemporary American religion, especially related to religion in public institutions, religious diversity, religious and moral aspects of healthcare, and religion and immigration. She is the author of three books, *Spiritual Care: the Everyday Work of Chaplains*, *Paging God: Religion in the Halls of Medicine*, and *Heartwood: The First Generation of Theravada Buddhism in America*, and a co-editor of *Chaplaincy and Spiritual Care in the Twenty-First Century* and *Religion on the Edge: De-Centering and Re-Centering the Sociology of Religion*. She founded and co-directed the *Transforming Chaplaincy Project* from 2015 to 2019, and in 2018 launched the Chaplaincy Innovation Lab.



**Ron Clark**  
**Chief Medical Officer Ambulatory Care Services**  
**Virginia Commonwealth University Health System**

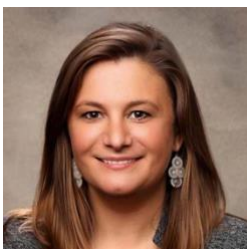
Dr. Ralph (Ron) Clark is Chief Medical Officer Ambulatory Care Services, VCU Health and Interim President of MCV Physicians. He previously served as Associate Dean for Clinical Activities at VCU School of Medicine and Interim President of VCU Medical Center. He serves on the Anthem National Hospital Advisory Panel on Value Solutions, the Community Advisory Board of Bath Community Hospital, and the Advisory Board of Lifenet Health Organ Procurement Organization. He is a Fellow of the American College of Physicians. He attended VCU School of Medicine and completed his residency at VCU’s Medical College of Virginia Hospitals.



**Laura McClelland**  
**Associate Professor and PhD Program Director**  
**Virginia Commonwealth University**

Laura McClelland, PhD is an Associate Professor and PhD Program Director in the Department of Health Administration at Virginia Commonwealth University. She has expertise in the areas of health administration, organizational behavior, leadership, and organization theory. Her research interests include—workplace compassion, employee well-being, and patient experience. Her research is published in leading health services and social science journals including *Health Services Research, Medical Care,* and *Human Resource Management Review* and cited in popular press outlets such as CNN and Kaiser Health News.

She also served on the National Academy of Medicine Scientific Advisory Panel on the Evidence for Patient and Family-Centered Care. She has also won multiple international teaching excellence awards. She received her Ph.D. in Organization & Management from Emory University and, prior to that, B.S. degrees in both Management and Economics from Villanova University. Before entering academia, she was a management consultant for PricewaterhouseCoopers and IBM.



**Kelsey B. White**  
**Assistant Professor, Chaplaincy Faculty Researcher Virginia Commonwealth University**

Dr. Kelsey White is an Assistant Professor and Chaplaincy Faculty Researcher for the Department of Patient Counseling in the College of Health Professions, Virginia Commonwealth University. She received her PhD in Public Health Sciences, concentration in Health

Management and Systems Sciences, as well as a Master of Science in Clinical Investigation Sciences from the University of Louisville. Her research primarily focuses on the integration of chaplains within healthcare delivery systems and their impact on healthcare access and quality. She includes research areas such as the social determinants of health, cross-organizational collaboration, and population health among her favorites. Beyond health services research, She is a board-certified chaplain and member of the Association of Professional Chaplains. Dr. White has authored many peer-reviewed publications about chaplaincy and co-edited [\*Evidence-based Healthcare Chaplaincy: A Research Reader\*](#). She is among the first cohort of [Transforming Chaplaincy](#) Research Fellows, and the Editor-in-Chief for the [Journal of Health Care Chaplaincy](#).

## Advisory Board

### **Drew Burrichter**

**Vice President, Mission for the Richmond Market  
Bon Secours Mercy Health**

Drew Burrichter serves Bon Secours Mercy Health as the Vice President, Mission for the Richmond market. He has been with Bon Secours and lived in Richmond since October 2010 and previously worked at Roper St. Francis Health System in Charleston, SC. Drew has an M.A. in Theology from The Catholic University of America, and a B.A. in Liberal Studies from St. Anselm College. Prior to a Chaplain Residency at Roper St. Francis Drew was Pastoral Associate at St. Benedict Catholic Church in Mt. Pleasant, SC from 2005-2009.

Drew was born and raised in West Chester, PA and is interested in sacramental theology. This led him to the belief that God is integrally present in the world and through our awareness of that presence in nature and humanity we appreciate and respect the “God within.” Drew is married and has 2 adult children. He and his wife Paula enjoy live performances of all sorts and spending time together enjoying nature.

### **Andrea Cotter**

**Corporate Vice President of Operations  
Centra Health**

Andrea Cotter is a healthcare executive, currently serving as the Corporate Vice President of Operations for Centra Health, in Lynchburg, Virginia. Andrea joined Centra in June of 2023. Andrea has a wide array of experience in hospital operations, beginning her career as an inpatient claim analyst for HCA in Richmond VA. She then served in a variety of front-line caregiver and support roles at VCU Health System during her didactic studies of the VCU MHA program; including patient registrar, transporter, and *US News and World Report* data liaison. Andrea completed her MHA program with a hospital operations fellowship at Sutter Health, in their flagship facility, Sutter Medical Center Sacramento. She remained employed with the organization post Fellowship, serving as a key inpatient operations project leader during the hospital’s monumental opening of their consolidated medical campus. This project included the decommissioning and closing of one inpatient

facility, the opening of a new inpatient tower, and the transitioning from paper records to an electronic health record in late 2015.

Andrea went on to serve in various hospital finance and operations roles across the country; Roper St. Francis Health System – Charleston SC, Wellstar Health System – Atlanta, GA, and most recently before Centra, the Chief Operating Officer at Bon Secours Southside Medical Center, part of the Richmond Bon Secours market in January of 2021. Andrea shares that she has always been fascinated with hospital operations and loves the dynamic environment of inpatient operations.

**Michael Elliott**

**Senior Vice President and Chief Operating Officer  
Virginia Commonwealth University Health System**

In this role, Michael Elliott is responsible for integrating the academic health system’s organizational strategic plan with its operations. Elliott leads efforts to deliver equitable, high-quality, cost-effective and integrated care across the health system’s hospitals and clinics. Elliott completed a Doctor of Pharmacy and Master of Science in Health Administration at Virginia Commonwealth University School of Pharmacy and School of Health Professions. Michael is a Fellow of the American College of Healthcare Executives, serves on the Board of the Virginia Hospital and Healthcare Association where he is the Vice Chair, serves on the American Hospital Association Region 3 Policy Board, is an elder at his church “The Hope Company”, and is a proud member of Alpha Phi Alpha Fraternity, Inc.

**Jerad Hanlon**

**CEO  
West Boca Medical Center**

Jerad Hanlon has over 20+ years of healthcare experience and currently serves as the Chief Executive Officer of West Boca Medical Center in Boca Raton, FL, part of the Palm Beach Health Network and Tenet Health. Prior to assuming the role of CEO, Mr. Hanlon most recently served as the Group Chief Operating Officer of the Palm Beach Health Network, a group of 5 hospitals located in Palm Beach County Florida, as well as the COO for St. Mary’s Medical Center and the Palm Beach Children’s Hospital. Prior to joining Tenet Health in 2019, Mr. Hanlon held numerous operations and administrative roles in a wide variety of healthcare settings, including for-profit, not-for-profit, and academic facilities located in Tennessee, North Carolina, and Virginia.

As a visionary leader, Mr. Hanlon has demonstrated continued success in building healthcare teams, by driving operational excellence, innovation, and strategic collaborations. Skilled at building relationships with physicians and staff, he is known as an effective communicator and partnership builder in the hospital and community. He is recognized for creating an organizational culture that thrives on authenticity, kindness, honesty, and transparency.

Originally from Richmond, VA, Mr. Hanlon earned his Bachelor of Science in Health Services Administration from James Madison University and a Master in Health Administration from Virginia Commonwealth University. He is very involved in his local community and serves on the board of the Boca Raton Chamber of Commerce, the board of the FAU Consortium for Graduate Medical Education and is an active member in his church, Christ Fellowship.

**Imani Jones**

**Director, Chaplaincy and Clinical Pastoral Education  
The Ohio State University Wexner Medical Center**

Rev. Dr. Imani Jones is an ordained minister in the United Church of Christ. A native of Cleveland, Ohio, Rev. Jones is a graduate of The Ohio State University and Princeton Theological Seminary with Bachelor of Arts, Master of Divinity and Master of Theology degrees, and has a Doctor of Ministry degree from Ecumenical Theological Seminary. Currently, Rev. Jones is the Director of the Chaplaincy Department at The Ohio State University Wexner Medical Center in Columbus, Ohio. Rev. Jones has a particular focus on the integration of African American voices in Clinical Pastoral Education curriculum development. She is a Board Certified Chaplain within the Association of Professional Chaplains and a Certified Educator in the Association for Clinical Pastoral Education. Rev. Jones is also the pastor, along with her husband, Colin, of Advent United Church of Christ in Columbus, OH, and an Adjunct Professor at Ecumenical Theological Seminary.

**Shawn LaFrance**

**Vice President for Population Health (Retired)  
Dartmouth Health – Cheshire Medical Center**

Shawn recently retired from serving as Vice President for Population Health at Dartmouth Health–Cheshire Medical Center in Keene, New Hampshire. Cheshire Medical Center is a hospital, safety-net provider, and the public health agency in the rural southwest region of NH. He received the NOVA/Dick Davidson Award-2022, from the American Hospital Association, for innovation in addressing the needs of people seeking treatment for substance use disorders in the region. Prior to that role, Shawn worked for more than 15 years at the Foundation for Health Communities in Concord NH and served as its founding Executive Director. The organization focuses on access to health care, quality of care, and community-based strategies in the state. Earlier in his career, he worked at The Commonwealth Fund, New York City Department of Health, and the Citizen’s Committee for the Children of NY in program development, grant-making, and public policy.

Shawn LaFrance is ordained as a Deacon in the Episcopal Church and serves in parish ministry and pastoral care in Concord NH. His diaconal formation program was in Boston with the Diocese of Massachusetts. Shawn’s community volunteer activities include leadership roles on the board of directors for: National Alliance on Mental Illness (NAMI)-NH; NH Hospice and Palliative Care Organization; NH Public Health Association; and Concord Public Library Foundation. He completed his graduate studies at Columbia University with a Master of

Public Health and Master of Science in Urban Planning and his undergraduate education was at the University of New Hampshire.

**Jason Lesandrini**

**Assistant Vice President for Ethics, Advance Care Planning, and Spiritual Health  
Wellstar Health System**

Jason Lesandrini, PhD, FACHE, LPEC, HEC, is the Assistant Vice President for Ethics, Advance Care Planning and Spiritual Health at Wellstar Health System in Georgia, where he leads the strategy and operations for the respective departments. He holds faculty appointments at Mercer University and South College in the Physician Assistant Programs. Jason is a widely recognized expert in outcomes metrics for ethics programs and served as an ethics expert to numerous professional organizations.

Jason is also founder and principal of The Ethics Architect. The Ethics Architect is an outcomes-driven healthcare consulting firm specializing in the assessment and execution of ethics programming, the creation of ethical cultures, and developing ethical leaders.

**Deb Marin**

**Director of the Center for Stress, Resilience, and Personal Growth  
Mount Sinai Health System**

Deb Marin, MD attended The Mount Sinai School of Medicine and the Mount Sinai Psychiatry Residency. Upon completion of her Residency, Dr. Marin completed a research fellowship in mood disorders at Cornell Medical College. Since her return to Mount Sinai in 1992, Dr. Marin has held several leadership positions, including Chief of Geriatric Psychiatry, Medical Director of the Department of Psychiatry, Dean for Clinical Research, and Chief Medical Officer. At Mount Sinai, Dr. Marin’s research focus has been in the area of memory disorders. She has been principal investigator in NIH funded grants that have investigated the clinical and biological correlates of normal aging and dementia. She has published several articles related to these topics. Dr. Marin’s clinical interests include the treatment of memory disorders and depression. Dr. Marin’s teaching interests are not only in the area of Psychiatry but also in the area of improving physician patient.

**Ronald Oliver**

**System Vice President of Mission & Outreach  
Norton Healthcare, Louisville, KY**

Rev. Dr. Ron Oliver, Ph.D., MBA, BCC serves as the System Vice President of Mission & Outreach at Norton Healthcare in Louisville, KY. He began at Norton in 1989 first as a chaplain resident, then PICU staff chaplain. He is endorsed by the Cooperative Baptist Fellowship and is a Board Certified Chaplain (BCC) through the Board of Chaplaincy Certification Inc. – an affiliate of the Association of Professional Chaplains (of which he was President 2018-2019). Ron serves on the Board of the Baptist Seminary of Kentucky, has been an Adjunct

Professor (bioethics) at Bellarmine University, and served on the team that conceptualized the integration of spiritual care into the American Red Cross.

**Trish Rodriguez**

**Senior Vice President, Clinical Services**

**Northern California Region Kaiser Foundation Health Plan and Hospitals**

Trish Rodriguez is the Senior Vice President, Clinical Services for the Northern California region of Kaiser Foundation Health Plan and Hospitals. She works across the delivery system to ensure access to healthcare services by 4.7 million members across all care settings, including care delivery strategy for Medicare and Medicaid, development of new models of care for complex needs and vulnerable populations, and operations oversight of pharmacy, continuum (including SNF, home health and hospice, dialysis, DME, and transport), mental health and other specialty care services, resource stewardship, e-Care, and PACE.

Prior to this role, she served as the Senior Vice President and Area Manager for Kaiser Permanente in South Sacramento and Elk Grove. She oversaw health plan and hospital operations, including Kaiser Permanente’s first Level II Trauma Center and the Geographic Managed Care (GMC) program. She began her career at Kaiser Permanente in 1991 at the Moanalua Medical Center in Honolulu as a Staff Nurse in the Emergency Department. She then took on roles with increasing responsibility in the Hawaii Region, ultimately serving as Assistant Hospital Administrator/Chief Operating Officer and Chief Nursing Officer. In 2008, she transferred to the Kaiser Permanente Sacramento Medical Center as its Chief Operating Officer. Ms. Rodriguez is a Registered Nurse and earned her master’s degree in public health from the University of Hawaii and a bachelor’s degree in nursing from the University of Lethbridge, in Alberta Canada. Trish has also attended the KP Executive Leadership Program at the Harvard Business School.

**Csaba Szilagyi**

**Director of Research**

**Assistant Professor**

**Transforming Chaplaincy & Rush University Medical Center**

Csaba Szilagyi, MDiv, MLA, MS, ACPE, FACHE is the Director of Research and an Assistant Professor at Rush University Medical Center, Department of Religion, Health, and Human Values. In this capacity, he serves as the Director of the Transforming Chaplaincy program at Rush with the mission to “promote evidence-based spiritual care and integrate research into professional practice and education by fostering a culture of inquiry.” His research focuses on chaplains’ collaborative and leadership roles in healthcare teams, interprofessional spiritual care, and Clinical Pastoral Education (CPE).

Csaba is an accomplished leader in integrating spiritual care into health services as an essential care domain. He has extensive experience directing spiritual care services and research in various healthcare settings. He is a Fellow of the American College of Healthcare Executives (FACHE) and board-certified in healthcare

management. Csaba holds graduate degrees in Management, Education, and Divinity from Harvard University, Johns Hopkins University, and Karoli Gaspar University, respectively. He is a Ph.D. candidate at KU Leuven. He is an ACPE Certified Educator and serves as the chair of the ACPE Research Committee and a member of the Board of Directors of the Foundation for ACPE.

**Lauren Taylor**  
**Assistant Professor**  
**NYU Langone School of Medicine**

Lauren A Taylor, MDiv, MPH, PhD studies governance and management of health improvement efforts within the United States and abroad. She worked briefly as a consultant for the Global Fund and Bill and Melinda Gates Foundation and has since written on the institutionalization of global health, how to reform the World Health Organization, the responsibilities of health systems to address social determinants of health and the problem of dirty hands for health policymakers. In 2013, she co-authored *The American Health Care Paradox* with Elizabeth Bradley.

For several years, Lauren co-taught Global Health Ethics at Harvard Medical School with Sadath Sayeed. In addition to her teaching at Wagner, she teaches a course on Professional Responsibility to students NYU Stern. She holds a Masters in Public Health from Yale and a Masters in Divinity from Harvard. Her PhD from Harvard Business School focused on organizational theory and business ethics. Lauren is an Assistant Professor in the Department of Population Health at NYU Grossman School of Medicine.

## Appendix 2

### Scoping Review Search Terms and Boolean Operators

Table e1. Search terms for Scoping Review

Database	Search Terms
Academic Search Complete	<p>((DE "Chaplains") OR (TI ("chaplaincy service" OR chaplain* OR "spiritual care provider" OR "spiritual care" OR "pastoral care" OR "religious care" OR "chaplaincy hospital service*" OR "hospital chaplaincy service*" OR "hospital chaplaincy services") ) OR AB ("chaplaincy service" OR chaplain* OR "spiritual care provider" OR "spiritual care" OR "pastoral care" OR "religious care" OR "chaplaincy hospital service*" OR "hospital chaplaincy service*" OR "hospital chaplaincy services") ) ) AND ( ( DE "Hospitals" OR DE "Psychiatric Hospitals" OR DE "Sanatoriums" OR DE "Outpatient Treatment" OR DE "Outpatient Commitment" OR DE "Outpatients" ) OR TI ( Hospital OR Medical Center OR medical centers OR cancer center OR Cancer centers OR ambulatory OR outpatient OR Telechaplaincy OR telehealth OR tele-health OR Clinic* OR Health system OR healthcare system OR Health center OR health centers OR Emergency Room OR Emergency Department OR Urgent Care OR Surgery Center OR Surgery centers OR surgical center OR surgical centers OR primary care OR long-term care OR longterm care OR nursing home OR nursing homes OR skilled nursing facility OR skilled nursing facilities OR SNF OR home health OR behavioral health center OR behavioral health centers OR mental health center OR mental health centers OR mental health facility OR mental health facilities OR veterans hospital OR veterans hospitals OR VA Hospital OR VA hospitals OR doctors office OR doctors offices ) OR AB ( Hospital OR Medical Center OR medical centers OR cancer center OR Cancer centers OR ambulatory OR outpatient OR Telechaplaincy OR telehealth OR tele-health OR Clinic* OR Health system OR healthcare system OR Health center OR health centers OR Emergency Room OR Emergency Department OR Urgent Care OR Surgery Center OR Surgery centers OR surgical center OR surgical centers OR primary care OR long-term care OR longterm care OR nursing home OR</p>

	<p>nursing homes OR skilled nursing facility OR skilled nursing facilities OR SNF OR home health OR behavioral health center OR behavioral health centers OR mental health center OR mental health centers OR mental health facility OR mental health facilities OR veterans hospital OR veterans hospitals OR VA Hospital OR VA hospitals OR doctor's office OR doctors offices )) )</p>
CINAHL	<p>((MH "Chaplaincy Service, Hospital") OR TI("chaplaincy service" OR chaplain* OR "spiritual care provider" OR "spiritual care" OR "pastoral care" OR "religious care" OR "chaplaincy hospital service*" OR "hospital chaplaincy service*" OR "hospital chaplaincy services") OR AB("chaplaincy service" OR chaplain* OR "spiritual care provider" OR "spiritual care" OR "pastoral care" OR "religious care" OR "chaplaincy hospital service*" OR "hospital chaplaincy service*" OR "hospital chaplaincy services" ) )  AND  ( ( (MH "Hospitals+") OR (MH "Ambulatory Care") OR (MH "Ambulatory Care Facilities+") OR (MH "Outpatient Service" ) ) OR TI ( Hospital OR Medical Center OR medical centers OR cancer center OR Cancer centers OR ambulatory OR outpatient OR Telechaplaincy OR telehealth OR tele-health OR Clinic* OR Health system OR healthcare system OR Health center OR health centers OR Emergency Room OR Emergency Department OR Urgent Care OR Surgery Center OR Surgery centre OR surgical center OR surgical centers OR primary care OR long-term care OR long term care OR nursing home OR nursing homes OR skilled nursing facility OR skilled nursing facilities OR SNF OR home health OR behavioral health center OR behavioral health centers OR mental health center OR mental health centers OR mental health facility OR mental health facilities OR veterans hospital OR veterans hospitals OR VA Hospital OR VA hospitals OR doctors office OR doctors offices ) OR AB ( Hospital OR Medical Center OR medical centers OR cancer center OR Cancer centers OR ambulatory OR outpatient OR Telechaplaincy OR telehealth OR tele-health OR Clinic* OR Health system OR healthcare system OR Health center OR health centers OR Emergency Room OR Emergency Department OR Urgent Care OR Surgery Center OR Surgery</p>

	<p>centre OR surgical center OR surgical centers OR primary care OR long-term care OR longterm care OR nursing home OR nursing homes OR skilled nursing facility OR skilled nursing facilities OR SNF OR home health OR behavioral health center OR behavioral health centers OR mental health center OR mental health centers OR mental health facility OR mental health facilities OR veterans hospital OR veterans hospitals OR VA Hospital OR VA hospitals OR doctor's office OR doctors offices ) )</p>
<p>PsychoInfo</p>	<p>((DE "Chaplains") OR (TI ("chaplaincy service" OR chaplain* OR "spiritual care provider" OR "spiritual care" OR "pastoral care" OR "religious care" OR "chaplaincy hospital service*" OR "hospital chaplaincy service*" OR "hospital chaplaincy services") ) OR AB ("chaplaincy service" OR chaplain* OR "spiritual care provider" OR "spiritual care" OR "pastoral care" OR "religious care" OR "chaplaincy hospital service*" OR "hospital chaplaincy service*" OR "hospital chaplaincy services") ) )  AND  (( DE "Hospitals" OR DE "Psychiatric Hospitals" OR DE "Sanatoriums" OR DE "Outpatient Treatment" OR DE "Outpatient Commitment" OR DE "Outpatients" ) OR TI ( Hospital OR Medical Center OR medical centers OR cancer center OR Cancer centers OR ambulatory OR outpatient OR Telechaplaincy OR telehealth OR tele-health OR Clinic* OR Health system OR healthcare system OR Health center OR health centers OR Emergency Room OR Emergency Department OR Urgent Care OR Surgery Center OR Surgery centers OR surgical center OR surgical centers OR primary care OR long-term care OR longterm care OR nursing home OR nursing homes OR skilled nursing facility OR skilled nursing facilities OR SNF OR home health OR behavioral health center OR behavioral health centers OR mental health center OR mental health centers OR mental health facility OR mental health facilities OR veterans hospital OR veterans hospitals OR VA Hospital OR VA hospitals OR doctors office OR doctors offices ) OR AB ( Hospital OR Medical Center OR medical centers OR cancer center OR Cancer centers OR ambulatory OR outpatient OR Telechaplaincy OR telehealth OR tele-health OR Clinic* OR Health system OR healthcare system OR Health</p>

	<p>center OR health centers OR Emergency Room OR Emergency Department OR Urgent Care OR Surgery Center OR Surgery centers OR surgical center OR surgical centers OR primary care OR long-term care OR longterm care OR nursing home OR nursing homes OR skilled nursing facility OR skilled nursing facilities OR SNF OR home health OR behavioral health center OR behavioral health centers OR mental health center OR mental health centers OR mental health facility OR mental health facilities OR veterans hospital OR veterans hospitals OR VA Hospital OR VA hospitals OR doctor's office OR doctors offices ))</p>
<p>PubMed / Medline</p>	<p>("Chaplaincy Service, Hospital"[Mesh] OR "chaplaincy service"[Title/Abstract] OR chaplain*[Title/Abstract] OR "spiritual care provider"[Title/Abstract] OR "spiritual care"[Title/Abstract] OR "pastoral care"[Title/Abstract] OR "religious care"[Title/Abstract] OR "chaplaincy hospital service*"[Title/Abstract] OR "hospital chaplaincy service*"[Title/Abstract])  AND  ("Hospitals"[Mesh] OR "Ambulatory Care"[Mesh] OR "Outpatient Clinics, Hospital"[Mesh] OR "Outpatients"[Mesh] OR Hospital[Title/Abstract] OR Medical Center[Title/Abstract] OR medical centers[Title/Abstract] OR cancer center[Title/Abstract] OR Cancer centers[Title/Abstract] OR ambulatory[Title/Abstract] OR outpatient[Title/Abstract] OR Telechaplaincy[Title/Abstract] OR telehealth[Title/Abstract] OR tele-health[Title/Abstract] OR Clinic*[Title/Abstract] OR Health system[Title/Abstract] OR healthcare system[Title/Abstract] OR Health center[Title/Abstract] OR health centers[Title/Abstract] OR Emergency Room[Title/Abstract] OR Emergency Department[Title/Abstract] OR Urgent Care[Title/Abstract] OR Surgery Center[Title/Abstract] OR Surgery centre[Title/Abstract] OR surgical center[Title/Abstract] OR surgical centers[Title/Abstract] OR primary care[Title/Abstract] OR long-term care[Title/Abstract] OR longterm care[Title/Abstract] OR nursing home[Title/Abstract] OR nursing homes[Title/Abstract] OR skilled nursing facility[Title/Abstract] OR skilled nursing facilities[Title/Abstract] OR SNF[Title/Abstract] OR home</p>

	<p>health[Title/Abstract] OR behavioral health center[Title/Abstract] OR behavioral health centers[Title/Abstract] OR mental health center[Title/Abstract] OR mental health centers[Title/Abstract] OR mental health facility[Title/Abstract] OR mental health facilities[Title/Abstract] OR veterans hospital[Title/Abstract] OR veterans hospitals[Title/Abstract] OR VA Hospital[Title/Abstract] OR VA hospitals[Title/Abstract] OR VA medical center[Title/Abstract] OR doctors office[Title/Abstract] OR doctors offices[Title/Abstract])  AND (("1998"[Date - Publication] : "3000"[Date - Publication]))</p>
Web of Science	<p>((TS=("chaplaincy service" OR chaplain* OR "spiritual care provider" OR "spiritual care" OR "pastoral care" OR "religious care" OR "chaplaincy hospital service*" OR "hospital chaplaincy service*" OR "hospital chaplaincy services" ) )  OR  (AB=("chaplaincy service" OR chaplain* OR "spiritual care provider" OR "spiritual care" OR "pastoral care" OR "religious care" OR "chaplaincy hospital service*" OR "hospital chaplaincy service" OR "hospital chaplaincy services"))))  AND  ((TS=("Hospital*" OR "Ambulatory Care" OR "Ambulatory Care Facilities" OR "Outpatient Service" ) ) OR (TI=(Hospital OR Medical Center OR medical centers OR cancer center OR Cancer centers OR ambulatory OR outpatient OR Telechaplaincy OR telehealth OR tele-health OR Clinic* OR Health system OR healthcare system OR Health center OR health centers OR Emergency Room OR Emergency Department OR Urgent Care OR Surgery Center OR Surgery centre OR surgical center OR surgical centers OR primary care OR long-term care OR long term care OR nursing home OR nursing homes OR skilled nursing facility OR skilled nursing facilities OR SNF OR home health OR behavioral health center OR behavioral health centers OR mental health center OR mental health centers OR mental health facility OR mental health facilities OR veterans hospital OR veterans hospitals OR VA Hospital OR VA hospitals OR doctors office OR doctor's offices)) OR (AB=(Hospital OR Medical Center OR medical centers OR cancer center OR Cancer centers OR ambulatory OR outpatient OR Telechaplaincy OR</p>

	telehealth OR tele-health OR Clinic* OR Health system OR healthcare system OR Health center OR health centers OR Emergency Room OR Emergency Department OR Urgent Care OR Surgery Center OR Surgery centre OR surgical center OR surgical centers OR primary care OR long-term care OR long term care OR nursing home OR nursing homes OR skilled nursing facility OR skilled nursing facilities OR SNF OR home health OR behavioral health center OR behavioral health centers OR mental health center OR mental health centers OR mental health facility OR mental health facilities OR veterans hospital OR veterans hospitals OR VA Hospital OR VA hospitals OR doctors office OR doctor's offices)))
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**Appendix 3.** Table e2. Articles reporting on chaplain interventions on service delivery according to clinicians & health care staff, n = 32

Study ID	Study Aim(s)	Study Design & Rigor	Study Sample	Setting	Intervention	Important Results
Bandini 2019	To explore the effectiveness of a workshop that equips non-chaplain clinicians to identify spiritual needs.	Quantitative - 4	Clinicians in long-term care	Skilled Nursing Facility	Spiritual Generalist Workshop	<ul style="list-style-type: none"> <li>• Clinicians reported greater ability &amp; comfort in identifying spiritual needs</li> <li>• Clinicians did not engage patients more frequently post-workshop</li> </ul>
Callis 2022	To explore nurses' experience of Tea for the Soul.	Qualitative - 1	Nurses	Community Hospital	Tea for the Soul	<ul style="list-style-type: none"> <li>• Nurses reported TFS helped promote their self-care &amp; maintain a sense of purpose in their professional practice</li> <li>• Nurses reported it renewed a sense of community &amp; felt renewed sense of capacity for compassion</li> </ul>
Campbell 2013	To assess the relationship between chaplain-led ICU initiatives & nurses' spiritual well-being, stress, & intent to stay in the field.	Quantitative - 2	ICU Nurses	Community Hospital	Spiritual Needs Nursing Program	<ul style="list-style-type: none"> <li>• Chaplains led interdisciplinary rounds, one-on-one interventions, guidance for family presence in resuscitation events, ethics drive-bys, &amp; debriefing sessions</li> <li>• No correlation between spiritual wellbeing, intent to stay or nursing stress</li> </ul>
Catlin 2019	To examine how an a cappella choir impacts the stress level of clinicians.	Quantitative - 4	Med-Surg Nurses	Community Hospital	Threshold a Capella Choir	<ul style="list-style-type: none"> <li>• Post-test scores indicated higher levels of centeredness,</li> </ul>

						calmness, peace, & connectedness
Copeland 2016	To develop a formal debriefing process with staff responding to resuscitation or trauma events. (Chaplain led occasionally.)	Quantitative - 4	Clinicians involved in the resuscitation / trauma events	Community Hospital	Post Code Pause	<ul style="list-style-type: none"> <li>• Clinicians felt more supported by peers with program (pre, 96% vs. post, 100%) &amp; more leader support (91% vs. 94%)</li> <li>• Clinicians felt they could honor the patient (36% vs. 61%), could regroup (43% vs. 61%)</li> <li>• Fewer felt pressure to return to work too quickly (59% vs. 70%)</li> </ul>
Costello 2023	To explore the Center for Stress Resilience & Personal Growth (CSRPG) community engagement model.	Mixed Methods - 3	Hospital Security officers	Academic Medical Center	Center for Stress Resilience & Personal Growth (CSRPG)	<ul style="list-style-type: none"> <li>• Program worked with 107 security officers</li> <li>• Officers felt better able to do their jobs, received tools &amp; skills to deal with crises</li> </ul>
Davis 2020	To evaluate the impact of a multifaceted resiliency intervention for staff.	Mixed Methods - 3	Clinicians working in the Pediatric Intensive Care Unit	Pediatric Hospital	Resiliency Bundle	<ul style="list-style-type: none"> <li>• Significant increase in group resilience within 6 months of bundle implementation</li> </ul>
Dodd-McCue 2004	To examine the relationship of the Family Communication Coordinator protocol on role stress of critical care nurses relative to organ donation cases.	Mixed Methods - 3	Nurses	Academic Medical Center	Family Communication Coordinator (FCC)	<ul style="list-style-type: none"> <li>• Associations found between the protocol &amp; lower job stress, role ambiguity, &amp; role conflict</li> <li>• Improvements in job satisfaction &amp; professional/organizational commitment</li> </ul>

Dodd-McCue 2005b	To examine effects of a protocol to increase organ donation on role stress & attitudes of critical care nurses.	Quantitative – 5	Critical Care Nurses	Academic Medical Center	Family Communication Coordinator (FCC)	<ul style="list-style-type: none"> <li>Nurses had lower levels of role stress after protocol</li> <li>Nurses had lower levels of role ambiguity &amp; role conflict,</li> <li>Decreases showed sustained improvement</li> </ul>
Fortune-Britt 2015	To study the implementation & subsequent periods of the W2SM program.	Mixed Methods – 3	Program Personnel	VA Hospital	Warrior to Soul Mate (W2SM)	<ul style="list-style-type: none"> <li>Program served 1,664 people &amp; 847 veterans</li> <li>Wide variation in cost</li> <li>Most important curriculum desired was on constructive conflict, emotional literacy, &amp; intimacy</li> </ul>
Freeman 2020	To explore the impact of a chaplain-developed mindfulness meditation intervention.	Quantitative - 2	VA Clinicians	VA Hospital	Spiritual Meditation Program	<ul style="list-style-type: none"> <li>29 staff members participated</li> <li>80% had a positive learning experience &amp; reported value in the experience</li> </ul>
Kao 2017	To explore the experience of a chaplain-psychiatrist partnership for interdisciplinary rounds.	Quantitative – 2	Clinicians from multiple disciplines	Academic Medical Center	Interdisciplinary Rounds	<ul style="list-style-type: none"> <li>Barriers to partnership included 1) lack of experience/training with spirituality &amp; 2) lack of knowledge/relationship with other clinician</li> <li>71% found integration helpful; helped participants understand patient needs &amp; appreciation of chaplains</li> </ul>

Keogh 2017	To explore the impact of spiritual care staff support intervention.	Quantitative - 2	Clinicians from multiple disciplines	Academic Medical Center	Chi Cart Ministry	<ul style="list-style-type: none"> <li>• 93.5% believed the Chi Cart communicated senior management's care</li> <li>• 92.1% felt less stressed during their shift</li> <li>• 86.3% believed they had better patient interactions post-intervention</li> </ul>
Keogh 2020	To demonstrate Chi Time program efficacy.	Quantitative - 2	Clinicians from multiple disciplines	Academic Medical Center	Chi Time	<ul style="list-style-type: none"> <li>• 66.7% (n = 272) said Chi Time helped them feel less stressed</li> <li>• 59.5% said helped them have better patient interactions</li> <li>• 57.7% said it showed them leadership valued them</li> <li>• 66.7% wanted it more frequently</li> </ul>
Kestenbaum 2015	To discuss clinicians' experiences of chaplaincy involvement in research.	Qualitative - 1	Physicians; Research team members	Outpatient Palliative Care	Spiritual AIM	<ul style="list-style-type: none"> <li>• Clinicians perceive that chaplains contribute uniquely to research team efforts based on their expertise</li> </ul>
Marin 2019	To report on a model for chaplain-led community engagement program between a medical center & a faith-based organization.	Quantitative - 2	Community health advisors	Community Setting	MICAH HEAL Project	<ul style="list-style-type: none"> <li>• 26 CHA completed the training</li> <li>• 14 community needs assessments were completed</li> <li>• Training included health topics, health connections with faith</li> </ul>
Mascaro 2021	To evaluate a compassion focused team intervention on clinicians' resilience,	Mixed Methods - 3	Clinical Research Coordinators	Outpatient Oncology	Compassion-Centered Spiritual health Team	<ul style="list-style-type: none"> <li>• Rated highly to improve burnout</li> </ul>

	well-being, burnout, & team civility.				Intervention (CCSH-TI)	<ul style="list-style-type: none"> <li>Majority reported benefits in resilience &amp; stress management</li> </ul>
McManus 2022	To understand the experiences of clinicians participating in Compassion Rounds.	Qualitative - 1	Clinicians from multiple disciplines	Community Hospital	Compassion Rounds	<ul style="list-style-type: none"> <li>Compassion Rounds positively impacted spiritual wellness for health care providers</li> <li>Physicians reported improved their ability to attend to spiritual wellness &amp; prevent/overcome burnout</li> </ul>
Mureau-Haines 2017	To improve team members' response and participation in resuscitation events.	Quantitative - 2	Team of Clinicians	Academic Medical Center	Family Facilitator / Family Support Person	<ul style="list-style-type: none"> <li>Chaplain functioned as Family Facilitator / Support Person</li> <li>Significant increases in all rated aspects of knowledge of family support role &amp; self-care strategies</li> </ul>
Smith 2022	To implement an evidence-based Spiritual Care Protocol for hospice care.	Quantitative - 2	Team of Clinicians; Other: documentation on patient encounters	Hospice	Spiritual Care Protocol	<ul style="list-style-type: none"> <li>Staff reported improvements in knowledge &amp; collaboration with spiritual care</li> </ul>
Teague 2019	To explore staff perceptions of chaplains serving as both chaplain & patient navigator.	Quantitative - 2	Nurses; Physicians	Academic Medical Center	Patient Navigation	<ul style="list-style-type: none"> <li>Majority felt the chaplain/patient navigator was useful to facilitate family meetings &amp; increased collaboration</li> <li>Physicians, generally, felt the chaplain/patient navigator was a helpful liaison</li> </ul>

Tracey 2023	To examine the impact of documenting patients' stories for clinicians.	Mixed Methods - 3	Clinicians in the Medical ICU	Academic Medical Center	This is My Story (TIMS)	<ul style="list-style-type: none"> <li>• Clinicians felt they could find out more about the patient's story ore quickly</li> <li>• Stories increased staff empathy towards patients &amp; perceptions of improved interactions with caregivers</li> </ul>
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**Appendix 4** Table e3. Articles reporting on chaplains' influence on service delivery according to patients, n = 39

Study ID	Study Aim(s)	Study Design & Rigor Score	Population	Setting	Intervention	Important Results
Alghanim 2021	To assess the effectiveness of a chaplain patient navigator on ICU costs and outcomes.	Quantitative - 5	Medical ICU patients & caregivers	Academic Medical Center	Chaplain Patient Navigator	<ul style="list-style-type: none"> <li>● Intervention group had a longer LOS, longer ICU LOS &amp; greater ICU costs</li> </ul>
Al Yacoub 2023	To document the costs and time commitment of Dignity Therapy intervention.	Quantitative - 4	Cancer patients 55 years and older + with palliative referral	Outpatient Palliative Care	Dignity Therapy	<ul style="list-style-type: none"> <li>● Chaplain interviews averaged 5.5 minutes longer than nurse interviews; approximately 7 hours per patient</li> <li>● Each DT session cost between \$331 - \$356 per patient</li> </ul>
Berning 2016	To assess the feasibility and effects of chaplain-led picture-guided spiritual care intervention.	Quantitative - 4	Mechanically ventilated adult ICU patients	Community Hospital	Picture Guided Spiritual Care Communication Board	<ul style="list-style-type: none"> <li>● Anxiety decreased by 31% after the initial visit</li> <li>● Among ICU survivors, 93% could recollect the intervention &amp; 81% felt more capable of handling their hospitalization</li> <li>● Stress levels dropped those who underwent additional screening</li> </ul>
Blum 2021	To assess the impact of a mindfulness meditation session.	Quantitative - 4	Adolescent patients on an acute psychiatric unit	Pediatric Hospital	Mindfulness Meditation Group	<ul style="list-style-type: none"> <li>● State-anxiety significantly decreased between pre- and post-mindfulness meditation upon first exposure</li> </ul>
Boehm 2020	To use a peer support program to develop an ICU recovery community to teach stress management and coping.	Quantitative - 2	ICU patients & family members	VA Hospital	Spirituality Group (THRIVE)	<ul style="list-style-type: none"> <li>● Group helped 94% of respondents feel emotionally supported, promoted coping,</li> <li>● Group gave 76% of respondents a better understanding of ICU care</li> </ul>

						<ul style="list-style-type: none"> <li>● 47% felt more in control of their lives</li> </ul>
Cipriano-Steffens 2021	To explore if a Spiritual Care Advocate improves end-of-life outcomes.	Quantitative - 4	Patients with metastatic cancer	Outpatient Oncology	Spiritual Care Advocate	<ul style="list-style-type: none"> <li>● Community spiritual support increased without changing quality of life of life</li> <li>● Perceived support from the healthcare team also increased</li> </ul>
Gelo 2015	To explore how visual artwork enhances conversations about their illness & hospitalization.	Qualitative - 1	Hospitalized patients	Community Hospital	Visual Thinking Strategies with Artwork	<ul style="list-style-type: none"> <li>● 90% found the experience to be positive</li> <li>● Participants shared experiencing comfort, peace, serenity, coping, reduced isolation, unity with nature, future focus, &amp; hope</li> </ul>
Grossoehme 2001	To explore if spiritual/religious issues are important to adolescents in psychiatric care.	Quantitative - 2	Adolescent psychiatric inpatients	Pediatric Hospital	Spirituality Group (Spiritual Issues)	<ul style="list-style-type: none"> <li>● 60% percent had not been asked about their religious or spiritual beliefs by any mental health professional, except a hospital chaplain</li> <li>● 94% found it the group helpful</li> <li>● 92% stated it helped them talk about their lives</li> <li>● 76% learned new coping skills</li> </ul>
Harris 2018	To determine the effectiveness of the “Building Spiritual Strength” (BSS) intervention.	Quantitative - 5	Veterans with PTSD	Outpatient Mental Health Clinic (VA Health)	Spirituality Group (Building Spiritual Strength)	<ul style="list-style-type: none"> <li>● PTSD symptoms did not differ between groups over time</li> <li>● Veterans had lower distress in their relationship with their Higher Power</li> </ul>
Kestenbaum 2017	To evaluate the feasibility and acceptability of the Spiritual AIM in outpatient palliative care. To see how	Quantitative - 4	Patients with advanced cancer	Outpatient Palliative Care	Spiritual AIM	<ul style="list-style-type: none"> <li>● Team identified the feasibility &amp; acceptability</li> <li>● Post measures showed an increased positive religious coping</li> </ul>

	the model impacts on spiritual well-being, coping, & symptoms.					<ul style="list-style-type: none"> <li>• Post measures showed no significant change in negative religious coping</li> </ul>
Kopacz 2017	To study the effects of Lectio Divina on religiosity, spiritual injury, & thoughts of violence.	Quantitative - 4	Patients with acute psychiatric service needs	VA Hospital	Lectio Divina	<ul style="list-style-type: none"> <li>• No change was observed in religiosity or thoughts of violence</li> <li>• Those with more than 2 sessions showed improvement in spiritual injury scores and thoughts of violence</li> </ul>
Levy 2006	To explore how spiritual coaching affects cancer patients' hope & distress.	Quantitative - 4	Radiation oncology patients	Outpatient Oncology	Spiritual Coaching	<ul style="list-style-type: none"> <li>• 15 out of 24 patients consented (62.5%) to spiritual coaching</li> <li>• Post measures showed increased hope &amp; some had decreased spiritual well-being</li> </ul>
Perez 2022	To evaluate the feasibility & acceptability spiritual care intervention for patients & caregivers; to determine the impact on psychospiritual and quality of life.	Quantitative - 5	Patients with stage IV lung or gastrointestinal cancer	Outpatient Oncology	Spiritual Care Assessment and Intervention (SCAI)	<ul style="list-style-type: none"> <li>• 24 of 82 patients &amp; 18 of 22 caregivers enrolled</li> <li>• Intervention associated with increased spiritual well-being &amp; quality of life for patients &amp; caregivers</li> </ul>
Piderman 2015	To document changes in spiritual well-being, coping, & quality of life in patients receiving spiritual legacy document.	Quantitative - 4	Individuals with brain cancers or neurodegenerative illnesses	Outpatient Oncology	Spiritual Legacy Intervention / Document (SLD)	<ul style="list-style-type: none"> <li>• 27 support pairs (SP; patients/caregivers) enrolled, 24 SP completed the Spiritual Legacy Document, &amp; 15 completed follow-up</li> <li>• Improvements found in spiritual wellbeing, religious coping, &amp; quality of life</li> </ul>

Piderman 2017	To investigate the feasibility of spiritual life review to create a Spiritual Legacy Document & the impact on their spiritual wellbeing, coping, & quality of life.	Quantitative - 5	Individuals with brain tumors and other neurodegenerative diseases	Outpatient Clinics	Spiritual Legacy Intervention / Document (SLD)	<ul style="list-style-type: none"> <li>• 32 SP enrolled, 24 SP completed SLD</li> <li>• Patients' spiritual wellbeing, spiritual coping, &amp; quality of life improved (time 1)</li> <li>• Patients' financial well-being decreased</li> <li>• Patients' improved in their sense of peacefulness &amp; positive religious coping</li> </ul>
Piderman 2020	To assess the feasibility & impact of spiritual life review intervention for spiritual wellbeing, coping & quality of life.	Quantitative - 4	Individuals advanced cancer; advanced neurological, cardiac, or pulmonary disease; renal failure	Outpatient Clinics	Spiritual Legacy Intervention / Document (SLD)	<ul style="list-style-type: none"> <li>• 130 SP enrolled, 59 completed SLD</li> <li>• Improvements were found spiritual wellbeing, quality of life, emotional wellbeing</li> <li>• Improvements in positive religious coping found</li> </ul>
Rummans 2006	To assess the feasibility & effectiveness of an interdisciplinary intervention on quality of life.	Quantitative - 5	Patients with advanced cancer undergoing radiation therapy	Outpatient Primary Care Clinic	Spirituality Group	<ul style="list-style-type: none"> <li>• Intervention patients had improved quality of life &amp; control group had decline in quality of life</li> </ul>
Sadras 2024	To explore primary care patients' experiences who received spiritual care.	Qualitative - 1	Primary care patients, a chaplain, and chaplains-in-training	Academic Medical Center	MESH Outpatient Program	<ul style="list-style-type: none"> <li>• Patients who received care reported sense of trust with providers &amp; satisfaction with care received</li> <li>• Patients reported that encounters with the chaplain contributed to the sense of having a safe space &amp; understanding the connection between spirituality &amp; their health</li> </ul>
Smigelsky 2022	To assess the impact of a moral injury therapy group on veterans.	Quantitative - 4	Veterans participating in REAL groups	VA Hospital	Moral Injury Group	<ul style="list-style-type: none"> <li>• Veterans who participated had decreased PTSD, depression scores, &amp; reduced thoughts of suicidality</li> </ul>

Sprik 2019	To identify the prevalence of religious/spiritual needs & the acceptance of spiritual care offered via phone.	Quantitative - 2	Oncology (surgical, medical, supportive, or radiation) patients	Outpatient Oncology	Telechaplancy	<ul style="list-style-type: none"> <li>● 30% of respondents identified at least one spiritual need</li> <li>● Younger age, female gender, anxiety, depression, &amp; higher distress were associated with specific spiritual concerns</li> <li>● Those with fear of death, struggle to find meaning/hope, &amp; anxiety increased were more likely to accept spiritual care over the phone</li> </ul>
Sprik 2021	To describe telechaplancy care for patients with religious/spiritual concerns. To assess the feasibility of telechaplancy.	Quantitative - 2	Oncology patients	Outpatient Oncology	Telechaplancy	<ul style="list-style-type: none"> <li>● 711 patients were screened; 30% had at least one religious/spiritual concern</li> <li>● Of those contacted, 61% spoke to a chaplain &amp; 33% completed the survey</li> <li>● 90% receiving intervention were very satisfied with the chaplain's prayer, strength-based support, &amp; help processing fears/ concerns</li> </ul>
Wilkie 2024	To compare the effects of palliative care with Dignity Therapy on quality of life.	Quantitative - 5	Oncology patients	Outpatient Palliative Care	Dignity Therapy (DT)	<ul style="list-style-type: none"> <li>● Those receiving DT had higher post-test dignity scores than pre.</li> <li>● Improved quality of life as compared to regular palliative care.</li> </ul>
Wilson 2023	To assess feasibility of a chaplain intervention to document patients' stories.	Quantitative - 2	Intensive care unit (ICU) patients	Academic Medical Center	This is My Story (TIMS)	<ul style="list-style-type: none"> <li>● Of the 387 patient referrals received, 193 were completed, 15 patients died, 131 declined, 34 were discharged, and 14 were discontinued upon transferal out of the ICU</li> </ul>

**Appendix 5** Table e4. Articles reporting on explicit spiritual care interventions with caregivers, n = 10

Study ID	Study Aim(s)	Study Design	Sample	Setting	Intervention	Important Results
Banyasz 2017	To explore family members' bereavement care preferences who had a loved one die in the hospital. To identify characteristic and grief differences in bereavement service use	Quantitative - 2	Caregivers who had a loved one die in the hospital past 3 - 18 months	Academic Medical Center	Bereavement Care	<ul style="list-style-type: none"> <li>• Top 5 important services offered: <ol style="list-style-type: none"> <li>1) time alone with the deceased</li> <li>2) a quiet room to be alone after the death</li> <li>3) sympathy cards from hospital staff</li> <li>4) memorial services</li> <li>5) chaplain support before/during time of death</li> </ol> </li> <li>• Caregivers who had complicated grief and/or depression had greater interest in services</li> </ul>
Betz 2019	To test the feasibility, acceptability, & fidelity of an intervention focused on decreasing caregivers' spiritual struggles	Quantitative - 4	Caregivers of those with cystic fibrosis	Outpatient Clinic	GuideSS_CF	<ul style="list-style-type: none"> <li>• 23 of 30 enrolled (70%); 18 of 23 remained (78%)</li> <li>• Intervention group maintained lower negative spiritual coping &amp; increased in positive spiritual coping</li> <li>• Control group had increased negative spiritual coping</li> <li>• Depressive symptoms decreased in both groups.</li> <li>• Adherence to daily airway clearance practices improved in both groups</li> </ul>
Boehm 2020	To develop a peer support program for patients & caregivers who has an ICU hospitalization	Quantitative - 2	Medical ICU & Surgical ICU patients & family members	VA Hospital	Spirituality Group (THRIVE)	<ul style="list-style-type: none"> <li>• 94% (n = 100) of respondents felt emotionally supported</li> <li>• Respondents reported that the group helped them cope &amp; created a sense of community</li> </ul>

						<ul style="list-style-type: none"> <li>● 76% (n = 81) had better understanding of critical illness</li> <li>● 47% felt in more control of their life</li> </ul>
Cullen 2024	To describe a support program for next of kin (NOK) of deceased patients	Quantitative - 2	Caregivers of patients who died in the Communicable Disease Response Unit & Palliative Care	Academic Medical Center	Bereavement Care	<ul style="list-style-type: none"> <li>● 63% (15 of 81) completed call</li> <li>● 17% (14 of 81) requested further bereavement support</li> </ul>
McManus 2022	To explore caregivers' experiences of clinicians who participated in Compassion Rounds	Qualitative - 1	Caregivers of Neonatal ICU patients	Community Hospital	Compassion Rounds	<ul style="list-style-type: none"> <li>● Parents of NICU babies reported the sense of improved spiritual wellbeing, feeling heard, and feeling connected</li> <li>● Fostered trust among team members &amp; parents</li> </ul>
Perez 2022	To assess the feasibility, acceptability & preliminary effects of SCAI on psychospiritual outcomes & quality of life	Quantitative - 5	Patients with stage IV lung or GI cancer & their caregivers	Outpatient Oncology	Spiritual Care Assessment & Intervention (SCAI)	<ul style="list-style-type: none"> <li>● 18 of 22 eligible caregivers enrolled (81.8%)</li> <li>● Caregivers (and patients) wanted more time with chaplain</li> <li>● Caregivers' quality of life improved over course of intervention</li> </ul>
Piderman 2017	To assess the feasibility & impact of a spiritual life review interview	Quantitative - 5	Support pairs with neurodegenerative diseases & their caregivers	Academic Medical Center	Spiritual Legacy Document	<ul style="list-style-type: none"> <li>● Patients &amp; caregivers had improvement in spiritual wellbeing, spiritual coping, &amp; quality of life</li> <li>● Patients demonstrated a decrease in financial wellbeing</li> <li>● Patients &amp; caregivers had improvement in peacefulness &amp; positive religious</li> </ul>

Steinhauser 2016	To identify the feasibility & acceptability a chaplain-led intervention to improve caregivers' well-being & coping	Quantitative - 4	Caregivers for patients with advanced cancer or ALS	Outpatient Palliative Care	Caregiver Outlook	<ul style="list-style-type: none"> <li>● 52% of 67 caregivers agreed to participate</li> <li>● 26 caregivers completed study</li> <li>● Caregivers appreciated the intervention helped them emotionally reflect &amp; take breaks, identify important support persons, engage in difficult conversations, &amp; improved communication skills</li> </ul>
Tartaglia 2000	To increase organ donation rates with a chaplain-led program	Quantitative - 2	Caregivers of hospitalized persons who were eligible for organ donation	Academic Medical Center	Family Communication Coordinator (FCC)	<ul style="list-style-type: none"> <li>● The FCC program reported an increase in consent &amp; donation rates</li> <li>● The consent rate for African Americans increased 15% over a 2-year period</li> <li>● Authors estimated that the program added 5 additional transplanted organs &amp; approximately \$783,000 in hospital income</li> </ul>
Torke 2023	To test the effectiveness of a chaplain intervention to improve family well-being & decision making	Quantitative - 5	Caregivers of ICU patients	Academic Medical Center	Spiritual Care Assessment & Intervention (SCAI)	<ul style="list-style-type: none"> <li>● Intervention group had lower anxiety than the control</li> <li>● The intervention group had higher rates of spiritual well-being</li> <li>● Intervention group had higher satisfaction with spiritual care</li> </ul>

**Appendix 6.** Table e5. Articles reporting on general chaplain care’s influence on service delivery according to clinicians

Study ID	Study Aim(s)	Study Design & Rigor	Study Sample	Setting	Important Results
Cadge 2011	To explore the pediatric physician-chaplain working relationship.	Qualitative - 1	Pediatric Physicians	Pediatric Hospital	<ul style="list-style-type: none"> <li>Physicians believe chaplains are part of the interdisciplinary team</li> <li>They report chaplains perform rituals, support patients/families &amp; help them navigate death</li> </ul>
Cunningham 2017	To explore the challenge & benefits of working alongside chaplains.	Mixed Methods - 3	Patients; Nurses; Physicians; Clinicians-in-training	Academic Medical Center	<ul style="list-style-type: none"> <li>87.57% of medical students &amp; 93.10% of residents agreed that chaplains were valuable team members</li> <li>Chaplains play a significant role in navigating communication with &amp; between patients / caregivers</li> </ul>
Fitchett 2011	To explore physicians’ perceptions of chaplains on pediatric palliative care teams.	Mixed Methods - 3	Pediatric Palliative Care Medical Directors	Pediatric Hospitals	<ul style="list-style-type: none"> <li>86% of programs reported a staff chaplain on their clinical team</li> <li>Medical Directors reported chaplains helped address spiritual suffering, navigate family-team communication, &amp; support to team members</li> </ul>
Flannelly 2005a	To identify the important functions of chaplains’ roles according to hospital administrators.	Quantitative – 2	Healthcare Administrators	US Hospitals	<ul style="list-style-type: none"> <li>Administrators at hospitals without chaplaincy services rated importance lower</li> <li>Meeting emotional needs of patients/caregivers was most important</li> <li>Providing religious rituals/services were least important</li> </ul>

Flannelly 2005b	To determine hospital directors' views about various chaplaincy functions.	Quantitative - 2	Directors of Medicine, Social Work, & Spiritual Care	US Hospitals	<ul style="list-style-type: none"> <li>• Six categories of activities identified: grief &amp; death, emotional support, community liaison, directives &amp; donation, religious services, consultation &amp; advocacy</li> <li>• Highest rated for importance: grief &amp; death care, prayer, &amp; emotional support, religious services, consultation &amp; advocacy</li> </ul>
Kyounghae 2017	To explore nurses' experiences with chaplains in the context of caring for critically ill patients / caregivers.	Qualitative - 1	Critical Care Nurses	Academic Medical Center	<ul style="list-style-type: none"> <li>• Nurses believe chaplains' roles overlap in care – such as listening, praying &amp; counseling</li> <li>• Nurses wanted earlier spiritual assessments to help enhance their care</li> </ul>
Liberman 2020	To examine relationship between chaplaincy interaction, employee job stress, & job satisfaction.	Quantitative - 2	Nurses	Academic Medical Center	<ul style="list-style-type: none"> <li>• Significant inverse relationship between frequency of chaplaincy interaction &amp; perceived stress</li> <li>• Significant positive relationship between religiosity &amp; rated importance for having a chaplain; rated helpfulness of chaplaincy</li> <li>• Chaplaincy interaction associated with decreased perceived employee stress for nursing staff</li> </ul>
Nedjat-Haiem 2017	To explore provider perceptions about roles & responsibilities for EOL care communication.	Qualitative - 1	Clinicians from multiple disciplines	Academic Medical Center	<ul style="list-style-type: none"> <li>• Chaplains' roles included encouraging conversation, helping others find peace in decision-making, &amp; providing active listening / enhance communication</li> </ul>

Nichols 2013	To evaluate the impact of adding a spiritual care program to a skilled nursing facility on staff.	Quantitative - 4	Clinicians within a skilled nursing facility	Skilled Nursing Facility	<ul style="list-style-type: none"> <li>• Increases in spiritual awareness &amp; satisfaction throughout the resident population</li> <li>• Spiritual support suggested to be vital in wellbeing &amp; quality of life at end of life</li> </ul>
Taylor 2015	To explore the spiritual care experiences of hospital-based healthcare providers.	Qualitative - 1	Clinicians from multiple disciplines	Academic Medical Center	<ul style="list-style-type: none"> <li>• Providers identified awareness of chaplain availability &amp; chaplains' focus on building relationships with providers &amp; staff</li> <li>• They recognized that chaplains are integrated at varying levels by unit &amp; chaplains meet providers, personal &amp; professional needs</li> <li>• Providers appreciate chaplains</li> </ul>

**Appendix 7.** Table e6. Studies that report the role of general chaplain care with patients, n = 16

Study ID	Study Aim(s)	Study Design & Rigor Score	Population	Setting	Important Results
Bandini 2017	To explore chaplains were involved in ethics consults for life sustaining treatment where conflict was religiously based	Quantitative - 4	Patients/caregivers with ethics consultations with disagreements over life sustaining treatments	Academic Medical Center	<ul style="list-style-type: none"> <li>• 25.2% of 95 ethics consults for life sustaining treatment came from religious concerns</li> <li>• Cases that involved non-White patients, non-English speaking, those born outside the USA, &amp; those with low income were most likely to have religiously centered conflict</li> <li>• Ethics consults with religiously centered conflict used chaplains in 19 of the 24(79.2%)</li> </ul>
Bay 2008	To evaluate the impact of chaplain care on religious coping, spiritual pain, and anxiety	Quantitative - 5	Patients with coronary artery bypass grafts	Community Hospital	<ul style="list-style-type: none"> <li>• There was an improvement in positive religious coping scores over time</li> <li>• Negative religious coping scores decreased over time</li> </ul>
Hirschmann 2022	To explore the provision of spiritual care for transgender & nonbinary patients recovering from gender-affirming surgeries	Quantitative - 2	Patients who underwent gender affirming surgeries	Academic Medical Center	<ul style="list-style-type: none"> <li>• 61% (n = 98) of patients expressed gratitude &amp; discussed hospital experience</li> <li>• 8% identified supportive religious / spiritual beliefs</li> <li>• 36% received prayer or blessing from the chaplain</li> </ul>
Hultman 2014	To explore health service utilization differences & spiritual needs of burn patients	Quantitative - 2	Burn patients	Academic Medical Center	<ul style="list-style-type: none"> <li>• Chaplains visited with 23.5% of patients (N=1,077)</li> <li>• Patients received (on average) 3-4 visits</li> <li>• Patients without spiritual care had larger burns, longer LOS, higher charges, &amp; higher mortality</li> </ul>

Idler 2015	To examine how general chaplain care operates in a religiously diverse urban context	Mixed Methods - 3	Palliative care patients	Academic Medical Center	<ul style="list-style-type: none"> <li>● Chaplain activities fell into category of “doing” or “being”</li> <li>● Visits with religious or spiritual topics were rare</li> <li>● Patients wanted to discuss “practical concerns” &amp; “ultimate concerns”</li> </ul>
Idler 2001	To explore if daily chaplain visits were associated with length of stay or patient satisfaction	Quantitative - 5	Patients with COPD admitted to a medical/surgical unit	Community Hospital	<ul style="list-style-type: none"> <li>● Patients receiving spiritual care stayed an average of 3 fewer days than those without</li> <li>● Patients receiving spiritual care reported greater satisfaction with their hospital stay</li> </ul>
Labuschagne 2021	To explore the relationship between chaplaincy care & ICU length of stay	Quantitative - 2	Patients admitted to the ICU	Academic Medical Center	<ul style="list-style-type: none"> <li>● Those with longer LOS were more likely to receive spiritual care</li> <li>● Bivariate analyses showed receipt of spiritual care within the first 48 hours of admission trended toward lower LOS</li> </ul>
Mascaro 2023	To explore the association between chaplains’ compassion capacity & linguistic behaviors with patient outcomes	Quantitative - 3	Hospitalized patients	One health system with 5 hospitals	<ul style="list-style-type: none"> <li>● Compassion capacity was associated with chaplains’ Linguistic Inquiry Word Count clout scores</li> <li>● Language demonstrated confident leadership, &amp; inclusivity</li> <li>● Patients seen by chaplains with higher clout scores had lower depression post-consultation</li> </ul>
McCormick 2015	To explore how patients and families perceive spiritual care during post-trauma recovery	Qualitative - 1	Adult patients & caregivers who experienced trauma	Level 1 Trauma Hospital	<ul style="list-style-type: none"> <li>● Patients/caregivers valued chaplains’ abilities to form relationships</li> <li>● Patients/caregivers valued chaplains’ abilities to help them find &amp; discuss meaningful experiences</li> </ul>
Muehlhausen 2022	To identify which chaplain activities patients/caregivers valued, reasons for seeking	Quantitative - 2	Hospitalized adults & their caregivers	One health system with multiple hospitals	<ul style="list-style-type: none"> <li>● Spiritual care sought for emotional support, spiritual support, ethical guidance, &amp; advanced directives</li> </ul>

	spiritual care, & expectations of spiritual care				<ul style="list-style-type: none"> <li>● Satisfaction was highest for those receiving emotional support, religious support, &amp; decision-making assistance</li> </ul>
Muehlhausen 2023	To assess the feasibility of outpatient spiritual care in oncology	Quantitative - 2	Oncology patients	Outpatient Oncology	<ul style="list-style-type: none"> <li>● Chaplains assess moderate to severe spiritual concerns in 45% of visited patients</li> <li>● Patients averaged 4 sessions</li> <li>● Follow-up data for 20 patients showed lower religious/spiritual distress &amp; increase in well-being</li> </ul>
Nichols 2013	To implement a spiritual care program & evaluate resident & staff satisfaction with the spiritual support provided	Mixed Methods - 3	Residents of skilled nursing facility	One system of multiple Skilled Nursing Facilities	<ul style="list-style-type: none"> <li>● Spiritual awareness &amp; satisfaction increased among residents</li> <li>● Spiritual support identified as important for wellbeing &amp; quality of life at the end of life</li> </ul>
Piderman 2010	To identify patient expectations of spiritual care, characteristics of those who want visits, & what patients consider important	Quantitative - 2	Patients recently discharged from hospitalization	Across hospitals	<ul style="list-style-type: none"> <li>● 70% of patients sought chaplain visit</li> <li>● Most important spiritual care activities: being reminded of God's care, support of family/friends, &amp; prayer/scripture</li> </ul>
Rabow 2004	To explore the impact of palliative care intervention for outpatients	Quantitative - 5	Patients with advanced congestive heart failure, COPD or cancer	Outpatient Primary Care Clinic	<ul style="list-style-type: none"> <li>● Intervention group had less dyspnea, anxiety, better sleep quality &amp; improved spiritual wellbeing post intervention</li> <li>● Intervention group had fewer primary care &amp; urgent care visits</li> <li>● No increase in emergency department visits, specialty clinic visits, hospitalizations, or hospital days</li> </ul>

Sharma 2016	To identify the impact of chaplain-specific skills on patient satisfaction	Quantitative 2	Patients discharged from hospital (who completed satisfaction survey)	Community Hospital	<ul style="list-style-type: none"> <li>• Most patients who received chaplain visits were Christian, older, Black or Hispanic, had lower education levels, &amp; spoke English or Spanish at home</li> <li>• Chaplains' religious/spiritual interventions were more strongly correlated with satisfaction than psychosocial interventions</li> </ul>
Tadwalkar 2014	To identify the effects of spiritual counseling on patients' quality of life	Quantitative 4	Patients with congestive heart failure	Academic Medical Center	<ul style="list-style-type: none"> <li>• Improvements were noted in spiritual wellbeing &amp; quality of life</li> <li>• Patients had increases in physical &amp; psychological symptoms measured by the MSAS</li> </ul>

**Appendix 8.** Table e7. Articles reporting on the provision of general spiritual care to caregivers, n = 6

Study ID	Study Aim(s)	Study Design	Sample	Setting	Important Results
Donohue 2017	To describe how the caregivers of hospitalized children use hospital chaplains	Quantitative- 2	Caregivers of hospitalized children	Academic Medical Center	<ul style="list-style-type: none"> <li>● 42% of parents requested a chaplain visit (n = 74)                             <ul style="list-style-type: none"> <li>○ Chaplains provided: religious &amp; secular services, family support &amp; comfort, help with decision making, understanding medical terminology, advocacy &amp; maintain hope / reduce stress</li> </ul> </li> <li>● 75% viewed chaplains as a member of the healthcare team</li> <li>● 38% reported that chaplains enhanced communication with medical personnel</li> <li>● 66% felt that the chaplain increased their satisfaction with hospital care</li> </ul>
Johnson 2014	To identify what aspects of chaplaincy care were associated with family satisfaction with ICU care	Quantitative - 4	Family members of patients who died in the ICU	Academic Medical Center	<ul style="list-style-type: none"> <li>● Chaplains' discussions of patients' wishes for end-of-life care were associated with increased overall family satisfaction with ICU care</li> <li>● Greater chaplain involvement &amp; more chaplain activities associated with higher family satisfaction</li> <li>● Chaplain engagement in family conference was associated with improved family satisfaction with decision-making</li> </ul>
McCormick 2015	To document patient & family perceptions of chaplain care	Qualitative - 1	Patients & their caregivers hospitalized after traumatic event	Level 1 Trauma Hospital	<ul style="list-style-type: none"> <li>● Key components of chaplain care: presence, relationship development &amp; space to discover, express &amp; make-meaning</li> </ul>

Michelson 2013	To explore chaplains' roles & responsibilities in end-of-life care	Qualitative - 1	Caregivers & clinicians in a Pediatric ICU	Pediatric Hospital	<ul style="list-style-type: none"> <li>• Clinicians &amp; caregivers identified chaplains as important for facilitating meetings, providing spiritual rituals, &amp; relaying important information</li> <li>• Chaplains enhanced trust in clinical relationships through consistency &amp; rapport building</li> </ul>
Muehlhausen 2022	To identify caregiver preferences for chaplain activities & to explore the association between satisfaction & those activities	Quantitative - 2	Patients & caregivers	Multiple hospitals within one health system	<ul style="list-style-type: none"> <li>• Patients &amp; caregivers wanted to see a chaplain for: (1) emotional support, (2) spiritual support; (3) ethical guidance</li> <li>• Emotional support activities received a 90% satisfaction rate</li> <li>• Religious support activities were performed with an 86% satisfaction rate</li> <li>• Decision making activities were performed with an 81% satisfaction rate</li> </ul>
Nageswaran 2022	To explore how caregivers identify the importance of religious & spiritual care	Qualitative - 1	Caregivers of children with medical complexities	Academic Medical Center	<ul style="list-style-type: none"> <li>• Parents believe religious &amp; spiritual practices powerful for healing &amp; coping</li> <li>• Spirituality played central role in decision making, but did not discuss with clinicians</li> <li>• Chaplains supportive, but not directly influential in decision making</li> </ul>



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