Pastoral care develops solutions to charting

By David Lewellen
Vision editor

When Fr. Basil Royston, BCC, arrived at O’Connor Hospital in San Jose eight years ago, he inherited a narrative system of charting pastoral care visits. But he found the format time-consuming. “By the time I had done 30 or 40 in a day, I thought that I should get a rubber stamp,” he said. “So I thought, why not get [checklist] boxes and check them?”

So Fr. Royston designed a form for charting with a checkoff list of pastoral interventions and limited space for narrative. In the near future, the form will be easily transmitted into an electronic format.

Because the Joint Commission now requires proof that spiritual care was provided, more hospitals now expect that chaplains will document their work in a patient’s medical chart. But documenting a spiritual encounter is more challenging than noting a pulse rate or a dosage of medication.

Across the country, one chaplain at a time, one system at a time, almost everyone has a different story about charting formats. Some like the narrative system, some like checklists; some are electronically formatted; some have efficient paper systems. But in the absence of a consensus around best practices, almost every institution is using a system of documentation that works within their clinical setting.

That may or may not be a problem. Settings and needs vary widely, and at every institution “the staff develops what makes sense to them,” said Sr. Colette Hanlon, SC, BCC, the spiritual care coordinator at Providence Care Center in Lenox, MA.

The drawback to a checklist system, Sr. Hanlon said, is that the interdisciplinary team may not know chaplain terminology — and there’s probably not a box to check for something as specific and comprehensible as “the patient is terrified of surgery and had a bad dream, and I called the surgeon.”

However, Sr. Hanlon has taught charting to CPE students, and also educated other healthcare professionals on what chaplains do, “so they know what a pre-op visit might involve.” The best setting for teaching charting, she said, is interdisciplinary, where the focus will not be just on pastoral-care language.

See Charting on page 6.
New programs, new food for thought offer inspiration

By Karen Pugliese
NACC Board Chair

On December 1st, in the midst of the city’s first winter storm, 14 Chicago-area NACC chaplains gathered with David Lichter; Dr. Bob Ludwig, director of the Institute of Pastoral Studies at Loyola University; and Dr. Bob O’Gorman, director of the M.Div. and Master of Pastoral Studies programs at the institute.

We were part of a unique day-long learning opportunity sponsored by Loyola in which best-selling author Fr. Richard Rohr led an audience of 630 participants in a powerful and challenging exploration of Scripture as a path to a spirituality which is grounded, traditional, and yet consistently “counter-intuitive” in its mature form. Over lunch, a diverse group of chaplains met with our new Executive Director, Bob O’Gorman, and Fr. Ludwig, greeted old friends, and made new collegial acquaintances.

The presentation coincided with the release of Richard Rohr’s newest book, Things Hidden: Scripture As Spirituality. At the same time, Bob O’Gorman revealed Loyola’s newest graduate program, responding to the call to minister in new ways within the Church. The school will offer three new focus areas — healthcare ministries, urban ministry, and ministry management and leadership. The curriculum, courses and workshops in this exciting new chaplaincy concentration were developed in consultation with the NACC and include basic CPE and a CPE residency. Upon completion of the degree, students will be ready for certification. This is a wonderful example of a hoped-for outcome in our Strategic Plan!

The institute now offers MA degrees in divinity, pastoral studies, pastoral counseling, spirituality, social justice, and religious education, as well as advanced graduate certificate programs in pastoral counseling, spiritual direction, social justice and religious education. Dr. O’Gorman told the chaplains attending the gathering that IPS will begin to offer specific workshops each semester as part of the new track in healthcare ministries. The workshops will be developed not only for those preparing for chaplaincy, but also for chaplains already in ministry in the Chicago area for their continuing education. We were given an opportunity to rank suggested workshops with an eye to our own interests and needs, to modify the topics, suggest additional subject matter, and offer potential qualified and experienced presenters.

Bob O’Gorman announced that he and Bob Ludwig, along with other educational leaders of graduate schools in pastoral ministry and theological studies, would meet with Catholic Health Association leaders to discuss partnership opportunities in preparing ministry leaders for education and healthcare. Our executive director, David Lichter, will also participate. And as you know (see David Lichter’s article on page 3), we continue to collaborate closely with Brian Yanofchick, CHA Senior Vice President of Mission Integration. We hope you see, as we do, an exciting synchronicity and a clearly growing momentum for our Strategic Plan.

Personally, I was deeply moved by the connections between Fr. Rohr’s reflections and my sense of the NACC’s own spiritual and strategic path. I encourage small groups of members to come together, either in person or in e-mail conversations, to reflect on the depth of wisdom and insight Rohr’s book offers. One of his major themes was the notion of “things hidden,” as Jesus said, “since the foundation of the world.” Rohr offered insight into how humanity comes to see and understand the Mystery of God revealed in our own lives, and trust the development of our spiritual consciousness and inner authority. He suggested that we are rediscovering transformation when we enter more fully into parabolic and paradoxical thinking.

Fr. Rohr challenged us to engage in “cellular” contemplative prayer, which takes us into the depths of the unconscious and awakens us to what is hidden in our often dualistic approach to life, even to our life of prayer. Dualistic hearts and minds are confounded by mercy, forgiveness, grace, and divine love. As we strive to implement our Strategic Plan, we need to avoid entrapment in an all-or-nothing mentality that devalues less than perfect achievements. Rohr encouraged us to see with the “third eye,” to detach from tightly held ideas, to engage in paradoxical versus oppositional thinking and discover graces hidden in the darkness of our own ignorance, fear, prejudice, blocks, and blind spots and self-protectiveness.

As we step over the threshold of a new year, I am reminded of both the Vision and Action and the Pastoral Care Summit, during which we prayerfully sought to become more comfortable with uncertainty and more at home dwelling in the Mystery of Possibility. Minds that continually re-process the past and worry about the future avoid the Gift of the Present Moment, and commit what Fr. Rohr playfully called the capital sin of superficiality. Imagine the potential energy unleashed by our members committed in prayer and action to what Rohr described as “Life as Participation” in the transformation of our own consciousness and of our association. Imagine the impact on our Church, our world!

Imagine the gifts of wisdom and insight that could emerge from small groups prayerfully reading and reflecting together. Consider taking the initiative to invite colleagues from various traditions to begin the new year by entering into a prayerful experience of faithful and graceful living into the Mystery and Paradox of Knowing and Unknowing. And let us know what is brought to light, even in the midst of winter’s darkness, from the hidden recesses of your hearts.

Karen Pugliese, MA, BCC, is a chaplain at Central DuPage Hospital in Winfield, IL.
NACC works to promote value of pastoral care

By David Lichter, D.Min.
Executive Director

Last month, I offered my observations on the first goal of NACC's strategic plan: to support association members with creative educational, spiritual, and communication opportunities. As I mentioned, reaching these goals will require effective strategy development in dialogue with you. I asked for your comments on my reflections, and I am grateful to the many of you who did just that. I ask you again to respond to this column.

Considering the value of belonging to an association such as the NACC, one thinks first about the immediate tangible benefits, such as Vision. I often weigh the cost benefit of my dues to belong to other organizations against those tangible benefits, and often come up short. Then I ask, "Is it worth the fees?"

I know we need to create more educational events related to goal one. However, I would like you to add into the value equation our efforts to address goal two, to promote the profession of chaplaincy. Fulfilling this goal carries many critical long-term benefits to your ministry that are less immediate or countable.

Think about this parallel. You as a member try to weigh the value of belonging to an association and to determine how best to judge its value. But in turn, the profession of chaplaincy seeks to position itself among other professions that are trying to judge the value of chaplaincy and deciding whether to support and invest in it. The seven objectives of this goal cover developing partnerships that will help develop and advance the value of chaplaincy.

The first objective is: advocate with and educate the bishops, The Joint Commission, the Catholic Health Association, the American Hospital Association, and CEOs of healthcare organizations on the value of certified chaplains and clinical pastoral educators, as well as on their role and needs. I had a good meeting with the NACC’s Episcopal Advisory Board at the USCCB’s General Assembly in November. They were positive about the plan and its direction. Several bishops came up to me at the end of the meeting to offer their help as needed. I sense genuine interest and support. Both Bishop Calvo, our new Episcopal Liaison, and Bishop Melczek, our former one, again expressed the invaluable ministry chaplains provide.

We greatly appreciate the growing partnership with CHA, especially through Brian Yanofchick, Senior Vice President of Mission Integration. With Brian's leadership and Tom Landry's groundwork, we have initiated both the Pastoral Care Summit in Omaha (see page 13) and the more recent survey on pastoral care that was conducted in December. CHA is very committed to collaborate with our chaplains, directors of pastoral care, and mission integration leaders to help identify and articulate the value of chaplaincy. Then we will be in a position to further advocate it with the American Hospital Association and CEOs of healthcare organizations. These target groups were of particular importance for the Marketing Task Force group that worked in the fall.

The second objective is: work with the Spiritual Care Collaborative, the Catholic Health Association, and The Joint Commission to establish and recognize standards for Pastoral Care departments and providers. At the CHA/NACC Pastoral Care Summit, this was identified as a key area, and we are organizing to address this need. However, we don't want to reinvent the wheel, but build on the best of existing standards, and work with the Spiritual Care Collaborative and The Joint Commission to build a consensus for standards that can be foundation for future programs. We have begun to address this objective well.

The third objective is: provide educational materials for use with colleges and ministry groups to promote chaplaincy as a vocation and profession. Several groups...
More certification materials now available online

Q. I am interested in applying for certification in 2008. Where can I find the necessary materials?
A. As of now, all of the forms that you will need are available online. Go to www.nacc.org and click on Certification to view and download or print the materials. Beginning this year, we will no longer mail certification materials. (And remember that your postmark deadline is Feb. 15.)

The same system now applies to members who need to renew their certification in 2008 or later. All forms are available at our website.

The NACC's newly revised standards, which you will refer to frequently in your application, are now also posted at our site under Certification.

Q. I'm a certified member, and I'm interested in being a volunteer interviewer in 2008. What steps should I take?
A. For every round of certification interviews, we need dozens of volunteer interviewers who are NACC-certified chaplains. There is one round of interviews scheduled for 2008, the weekend of Oct. 4-5. To express your interest in participating as a certification interviewer in the fall, please send an e-mail to certification@nacc.org. We will respond to discuss time commitment, training, and other logistics.

Q. Will I have opportunities to learn more about certification and renewal of certification at the Indianapolis conference?
A. Yes. We will again offer the workshops we have offered in previous years, led by members of the Certification Commission. There will be four sessions: one to address your questions about the certification process, one to cover our updated process for renewal of certification, and one to discuss supervisors' certification and renewal of certification. Additionally this year, we will present a session on training to become a certification interviewer.

Pastoral Care
Continued from page 3

are converging on this objective. In the fall, both the Marketing and Recruitment Task Forces provided some good direction here. Also at the Pastoral Care Summit, a group offered strategies for promoting chaplaincy to these educational and formational entities. We will integrate the efforts of these task forces in the coming year. Also, CHA invited us to participate in a convening of leaders in higher education to explore the future leadership needs, and chaplaincy was part of that discussion. We plan to have some sample materials that can be used for these higher education and ministry groups by Conference 2008.

The fourth objective is: promote CPE programs and increase the number of CPE supervisors. At their November board meeting, the NACC board spent some time discussing this need. Also, I was grateful to attend the ACPE National Convention in October and visit with several CPE supervisors — some who are certified only with ACPE, and others with dual certification. We need to be in serious dialogue with ACPE, which also feels the urgent need for more CPE supervisors. We are exploring the appropriate partnership with them to address this objective.

The fifth objective is: Benchmark staffing and wages of professionals with comparable training and experience. A first step to meeting this objective is getting updated data on staffing and wages within our own profession. As mentioned earlier, we undertook a survey with CHA in December, and will have results in early spring. We are also conducting a compensation survey with the Spiritual Care Collaborative in early 2008 that will provide us with very helpful data for further benchmarking our profession. From this basis we can take further steps to address this objective.

The sixth objective is: provide resources to assist with developing and sustaining excellent spiritual care services. The Pastoral Care Summit provided an opportunity for many of you to encourage collaborative efforts. I want NACC members to be able to access such resources on the NACC website. You know better than I the rich resources we already have among our members. Now it’s a question of getting members to send in their resources, and making sure our website is very user-friendly. We have a ways to go here, but we can make this happen!

The seventh objective is: partner with clinical research faculties in initiating studies on the value of professional spiritual care in healthcare settings. Again, at the Pastoral Care Summit, we had some select representation of researchers who have experience in this area and want to partner with us. We have solid potential here also.

Overall, as you can see, the Pastoral Care Summit provided an invaluable foundation for addressing most of the areas of this goal. We look forward to advancing this work with those who participated, and many who could not participate.

My next Vision article will reflect on goal three: To strengthen the NACC's relationship within the Catholic Church. I look forward to a great 2008 with you!
NACC welcomes newly certified members

Congratulations to the following NACC members who have been approved for chaplain certification following their interviews in October:

Mr. Pedro J. Acosta Zapata, Greenfield, WI
Mrs. Linda L. Amato, St. Clair, MI
Mrs. Maria A. Benoit, Apple Valley, CA
Mr. Isaac J. Brown, Portland, OR
Mr. Stanley L. Buglione, Niles, IL
Bro. Robert E. Campbell, Albuquerque, NM
Ms. Sherry L. Christ, Adrian, MI
Rev. Kenneth A. Chukwu, Chatsworth, CA
Sr. Annemarie T. Colapietro, SNJM, Alameda, CA
Rev. Luke K. Kalarickal, Tyler, TX
Ms. Lorena M. Klinnert, St. Paul, MN
Mrs. Laura L. Law, St. Charles, MO
Ms. Ann-Marie Lemire, Eugene, OR
Ms. Mary Jane Lipinski, Marshfield, WI
Ms. Sandra B. Lucas, Waterville, ME
Deacon Victor V. Machiano, McKinney, TX
Rev. Anthony Madiu, Uniondale, NY
Rev. Augustine C. Manyama, Portland, OR
Sr. Diane M. McManus, SSJ, Philadelphia, PA
Rev. Elias N. Menuba, Hartford, CT
Mr. Ronald S. Michels, Ripon, WI
Mrs. Debra T. Montelongo, Fairfax Station, VA
Mrs. Karen A. Nehls, Muskego, WI
Rev. Godwin T. Nnamezie, Canon City, CO
Rev. Remigius O. Nwabichie, Bridgeport, CT
Ms. Coleen A. O’Neill, Grand Island, NE
Rev. Charles M. Obiawara, Delphos, OH
Rev. Nelson O. Ogwuegbu, Baltimore, MD
Rev. Charles U. Okorougo, Lake Charles, LA
Rev. Eijeke I. Onyenagubo, Syracuse, NY
Sr. Christiana C. Onyewuche, EHU, Boston, MA
Rev. Andrew A. Phiri, Oak Park, IL
Sr. JoAnn Poplar, SSJ-TOSF, Garfield Heights, OH
Dr. Linda D. Sclarer, Oakland, CA
Mrs. Dorothy L. Sexton-Nagel, Batavia, NY
Sr. Bridget C. Zanin, MSC, Chicago, IL
We also congratulate the following members on their certification:

Supervisory Candidate
Ms. Theresa Lowther, Buffalo, NY

Associate Supervisor
Sr. Nancy Beckenhauer, OSU, Pepper Pike, OH

Thank you to our volunteers

The NACC wishes to thank the following members who made the certification weekend possible:

Interviewers
Rev. Milton N. Adamson, CSC
Mr. Bruce C. Aguilar
Dr. Linda M. Arnold
Mr. David C. Baker
Ms. JoAnn Gragnani Boss
Ms. Phyllis A. Bowling
Mr. Willard J. Braniff
Sr. Anne K. Breitag, OP
Rev. Michael E. Burns, SDS
Sr. Carol E. DeCrane, CSA
Mrs. Allison S. DeLaney
Mr. Michael J. Doyle
Sr. A. Louise Eggen, OSB
Sr. Nancy D. Fiasig, OSB
Bro. Daniel J. Gallucci
Sr. Pauline E. Gilmore, FMM
Sr. Suzanne C. Giro, CSJ
Sr. Mary Ellen Gleason, SC
Sr. Rose S. Grabowski, SSJ-TOSF
Sr. Colette Hanlon, SC
Ms. Jean M. Harrington
Ms. Deborah K. Heen
Sr. Gloria Jean Henchy, CDP
Sr. Marilyn Herr, OSF
Sr. Susan M. Holmes, OSB
Dr. Carolyn M. Jurkowitz
Mrs. Kathy J. Kaczmarek
Mrs. Susan M. Kangas
Mr. William H. Korthals, Jr.
Rev. Philip G. Krahman
Ms. Janice A. Labas
Ms. Aofie C. Lee
Mr. James P. Letourneau
Ms. Martha L. Leven
Ms. Therese Lowther
Ms. Theresa Maikisch
Rev. Dean V. Marek
Margaret C. Matacata
Ms. Carol Mazurek
Dr. Dennis McCann
Deacon William N. Mich
Dr. Anne Murphy
Sr. Mary J. O’Hara, OP
Rev. Gerald U. Onuoha
Sr. Ellen Poché, CSJ
Sr. Karen J. Poznialk, SNDdeN
Ms. Elinor D. Quill
Mrs. Ellen K. Radday
Mr. George P. Reed
Rev. Basil G. Royston
Sr. Maryanne Ruzzo, SC
Ms. Dorothy M. Sandoval
Mr. Timothy G. Serban
Sr. Alice L. Smitherman, OSB
Ms. Barbara Sorin
Ms. Janice K. Stanton
Sr. Maureen Stocking, OP
Mr. Michael L. Sullivan
Miss Mary M. Tooie
Ms. Kathleen A. Vander Velden
Deacon Thomas J. Waken
Ms. Myra J. Wentworth
Ms. Marilyn Williams

Interview Team Educators
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Mr. Robert J. Barnes, Woodruff, WI
Ms. Annette Castello, Venice, FL
Ms. Cathy Connelly, Columbia, SC
Ms. Carmelia L. Hanemann, Milwaukee, WI
Ms. Judith A. Shemkovitz, Cleveland, OH
Dr. Jane W. Smith, Columbia, MO

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Dr. Susanne Chawszczewski, NACC, Milwaukee, WI
Mrs. Catherine S. Colby, Providence St. Vincent’s Medical Center, Portland, OR
Ms. Kathleen Eldridge, NACC, Milwaukee, WI
Sr. Mary A. Gallagher, OSF, St. Elizabeth Medical Center, Brighton, MA
Mrs. Angie F. Vorholt-Wise, DePaul Hospital, Bridgeport, MO
Different settings — acute care, long-term care, psychiatric, ER, hospice — have different needs. Sr. Hanlon said that her students have taken the model she taught to other systems, but “a lot depends on the leadership of your department” as to what format is used. Some places, she said, simply put a sticker on the folder to indicate that the chaplain visited or that the patient received a sacrament — “and that’s what a nurse will look at, at 1 o’clock in the morning.”

At her previous job at The Hospital of St. Raphael in Connecticut, Sr. Hanlon held quarterly “charting field trips,” for everyone in the pastoral care department to review. She would take 10 charts at random from each unit and check the percentage that had been visited by a chaplain and the percentage that had substantial charting notes. It was a chance for the emergency-room chaplain to learn how the ob-gyn chaplain worked, and vice versa, and for everyone to share good or bad examples.

“Charting is about communication in general,” said George West, director of chaplain services at St. John’s Regional Medical Center in Oxnard, CA, and St. John’s Pleasant Valley Hospital in Camarillo, CA. His staff, he said, has learned to chart both for one another and for other departments. Internally, for instance, they might say, “The patient is not in touch with her/his mortality,” but to the medical staff they might say, “The patient expects to return to baseline.”

Fr. Royston said that training the nurses at O’Connor to fill out the spiritual assessment grid has “made a huge difference in terms of nurse involvement and patient satisfaction.” Nurses find it helpful to know more of the patient’s background, he said, and “no other place in the chart are most of those things recorded.”

The “spiritual risk assessment” form at O’Connor asks trained nurses or pastoral visitors (community clergy or trained volunteers) to identify factors in the patient’s physical, mental or spiritual condition that could put them at risk for a crisis. Fr. Royston inputs the results into a database and assigns his four full-time chaplains to visit the high-risk patients. If someone is emotionally unstable, or has a negative diagnosis, or broken family relationships, it’s helpful for the chaplain to know in advance.

“Pastoral visitors have no business looking at the medical section” of a chart, Fr. Royston said, but the professional chaplains sometimes find it useful background and a supplement to what patients tell them directly.

Space for notes is limited, because “we didn't want people writing the wrong things,” Fr. Royston said. “We can’t say that a patient seems depressed. We’re not qualified to make psychiatric evaluations.” But for major, intense, unusual meetings, O’Connor Hospital’s chart has a half-page left open for notes.

At Mercy Fitzgerald Hospital in Darby, PA, Sr. Angela Fellin, RSM, prefers that her department do the initial spiritual assessments. “99 percent of patients don’t know what a chaplain will do for them,” she said. If a nurse is asking the questions, “it scares them.” But she and her four part-time priests manage to see every new admit in key departments – ICU, emergency room, cardiac, and psychiatric.

As the only certified chaplain on staff, Sr. Fellin has trained the part-time priests to record their work on a paper form adapted to their own purposes. (Mercy Fitzgerald is going electronic, but it is not friendly to pastoral care so far: “We have to go through about 10 screens.”)

The form, which is filed directly with a patient’s progress notes, provides a checklist in which the chaplain can fill in as many boxes as needed (e.g. “guilty,” “grieving/sad,” “anxious/fearful,” “resistant”) and also a space for comments.

Teaching her coworkers is an ongoing process. “At every department meeting, I go over some aspect of charting,” she said. She also sits on a hospital committee that reviews patient charts and gets a look at the bigger picture.

Interacting with other departments can also be promoted by using their charting system. The pastoral care department at Central DuPage Hospital in Winfield, IL adapted the hospital’s McKesson system to include chaplaincy. “We said, What’s the purpose of doing this?” said chaplain Karen.
Pugliese, BCC, “and it was to work with the interdisciplinary team.” So chaplains asked nurses what was most important to them in the chaplain’s spiritual assessment of the patient, and asked themselves what spiritual information gleaned by the nurses was most important to them.

Questions were added to the electronic Patient Needs Assessment for nurses to ask all their patients if they wish to see a chaplain, to receive Catholic Communion and anointing, or to notify their church. Nurse documentation of the responses generates reports for the pastoral care department.

The spiritual care section of the electronic medical record now has checklists for the chaplain to complete afterward identifying the referral source (patient, family, staff or other chaplain), when the initial spiritual assessment was completed by the chaplain, whether the spiritual needs were identified and met, and whether there is an ongoing plan of care (for example, spiritual distress, end-of-life issues, emerging crisis, ethical moral concerns.)

Narrative windows, where the chaplain writes a succinct summary of the encounter, are not for revealing a patient’s confidential fears about God, death, or abandonment, but to give a general sense of their state of mind. If, for instance, a patient asks a chaplain to help with life review, it’s a signal that the person knows he is dying – important information for the doctor or nurse.

During the ten years that Michelle Lemiesz, BCC, has been at Mount Carmel Health System in Columbus, OH, spiritual care charting has moved to a medical format, with assessment, plan of care, and outcomes using the HBOC Care Manager system.

Chaplains at Mount Carmel educate and assist patients in filling out advance directive forms and indicate the outcome of the visit with check-boxes in order to inform the patient-care team that the referral has been completed. The chart can show which forms the chaplain gave the patient, and what the patient’s response was (not interested, thinking about it, consulting with family, etc.)

Mr. West said that St. John's advance directives are charted separately and open for all care staff to review. The treatment limit/no code status of the patient appears in the Misys system in the same icon that alerts caregivers to allergies — i.e. noting a treatment limit. Advance directives are a primary responsibility for St. John’s chaplains, as well as charting family conferences and affirming code status orders.

Mount Carmel’s system allows chaplains, case managers, social workers, and nurses to refer needs and observations to each other. “It allows each discipline to have a paper trail,” Ms. Lemiesz said. If, for instance, a patient mentions a recent death in his family, the nurse will refer the patient to chaplaincy for a follow-up assessment. Doctors routinely order chaplain visits as part of the patient’s care, and standard orders of care exist for some diagnoses (stroke, amputation, new diagnosis of cancer). The physician will read the chaplain’s assessment and include them in the plan of care for the patient as needed.

Ms. Lemiesz said that 95 percent of the charting done by chaplains will contain at least some narrative, “short and sweet and pertinent.” Any line in the charting system can be clicked to bring up a box to type in comments. When the document is saved, it will produce a color code to show it has become a permanent part of the chart.

“It’s important to have a good working relationship with a specific IT person who understands what chaplains do.” said Mr. West. “Charting is basically a common task for us all, but it is a very complex subject with many opinions and systems.”

What do you think?

We have gathered information from half a dozen chaplains for this article, but there are nearly 3,000 of you in the NACC — and as you know, charting is a field with many approaches and not a great deal of consensus.

We would like to continue this discussion online in the coming weeks and months. If you have ideas to share, please e-mail them to dlewellen@nacc.org. We will post them on our website and give you updates on new developments through NACC Now.
Marathon swim’s unexpected outcome full of grace

By Mary Johnson

A color guard, the national anthem, lots of supporters – what had drawn this much attention to two women in a swimming pool?

We were planning to swim for 24 hours straight, and it was a good cause: the 2007 Silent No More Swim to raise awareness about and research funds for ovarian cancer. But even so, I got choked up during the national anthem. I realized that everyone was singing along with the recording and most had their hands over their hearts. It was very moving.

Claire Casselman and I had a history of “unusual” swimming events. In 2004 we swam nearly 50 kilometers down the Missouri River to celebrate my 50th birthday. Now, here we were about to embark on another swimming odyssey. We aren't extreme athletes, but we had the advantage of a compelling cause. We knew we would be motivated if we kept our focus on the women diagnosed with ovarian cancer as well as the need for ongoing public education about the disease.

Claire had flown in to Rochester, MN, that morning from Ann Arbor, where she works as a clinical social worker at the University of Michigan Comprehensive Cancer Center. People began gathering by the pool about an hour beforehand. They were our friends, our co-workers, ovarian cancer advocates, curious onlookers, members of the public who had read about the event in the local newspaper, and a sprinkling of surviving spouses.

After the Color Guard retired, we jumped into the water. All of our supplies sat by the edge of the pool: flippers, kickboards, towels, extra goggles, and bottles filled with a mixture of water and electrolyte replacement. Medical personnel were also there, watching over us, encouraging us to drink and eat on a regular basis, and giving shoulder massages during our breaks. When Claire and I signaled our readiness, the lifeguard blew a whistle and we started swimming. I was all pumped up on adrenaline. I had to remind myself to relax and slow down. It was important that I get into my “zone.” Most swimmers can achieve an automatic pilot that allows us to free our minds. It is possible to actually forget we are swimming. That is where I wanted to go.

Ovarian cancer is a significant health issue in North America, with over 25,000 women in the U.S. and 1,200 women in Canada diagnosed each year. Unfortunately, approximately 75% of women have advanced disease at the time of diagnosis. The five-year, disease-free survival rate for women diagnosed with advanced ovarian cancer is less than 20%, according to the Mayo Clinic Guide to Women’s Cancers.

One patient advocacy group that raises funds for ovarian cancer research is the Minnesota Ovarian Cancer Alliance (MOCA). Since its founding in the late 1990s, MOCA has provided substantial grant funding to institutions in the state of Minnesota conducting research in ovarian cancer. In 2003 I was fortunate to receive a MOCA grant for a study titled, “The use of a spiritual intervention to enhance mood states, spiritual well-being and quality of life in women with recurrent ovarian cancer.” I have come to admire the work of MOCA and was looking for ways to contribute to their mission, since part of my clinical focus is women with ovarian and other gynecologic cancers. The marathon swim project seemed like a great approach to awareness-raising.

So in 2006 I swam a 12-hour marathon by myself. I jumped in the water at 5 a.m. on a Friday without fanfare. I swam for 50 minutes out of every hour until 5 p.m. We raised awareness — and almost $1,000 an hour. I felt great at the conclusion and only slightly fatigued.

With confidence from that experience, I began the 2007 swim. My plan was to take it one hour at a time. I asked my chaplaincy colleagues to pray that my heart would be open to God’s grace. This grace had sustained me during the 2006 swim, making it seem almost easy. But during the 24-hour marathon, I was showered with different kinds of grace, in ways I might not have thought I wanted, but never imagined.

The first several hours of swimming were exhilarating. I felt strong and hopeful. I worked to maintain a here-and-now focus, instead of giving in to the temptation of imagining the finish before I had reached it. Many people stopped by the pool to cheer us on. Among them were breast and gynecologic cancer patients who had come to an annual conference hosted by the Mayo Women’s Cancer Program. They had heard about the swim and showed up at the pool to provide moral support. I knew several of them, and their presence was very motivational.

Claire and I planned to swim at the same time, but not together. We have different approaches to working out. I wanted to plan each hour carefully and to execute that plan, almost like a job. We would both swim for 45 minutes and take the last 15 minutes of the hour to get out of the pool, do our self-cares, and refresh before beginning all over again. Replacement swimmers were scheduled to keep the laps going during our breaks.
I planned to begin each hour with a vigorous half-mile swim and then spend the rest of the time on a kickboard, moving back and forth using flutter, scissor, and whip kicks. When using the kickboard, I could chat with people who would walk alongside of the pool. It was a way for us to get support and for our many visitors to become a part of the total effort.

But I began to have difficulty after about 10 hours of swimming. I couldn't keep up with the required fluid intake and became dehydrated. One might think that hydration isn't an issue for swimmers, but a powerful process of dehydration takes place with vigorous activity in the water, and the fluid has to be replaced or weakness, light-headedness, nausea and lethargy set in. I tried to recover, pushing fluids and trying to eat bites of high-sugar foods. Despite my efforts, I fell behind. As I grew weaker, swimming became a daunting challenge and each lap became a major effort.

After about 12 hours of swimming I began to have difficulty keeping fluid or food down. Hypothermia began to set in as my body struggled to warm itself. The same water that felt tepid at the start of the swim now felt ice-cold. I battled through the next three hours or so, trying to keep up with hydration, but I fell farther behind with each passing hour. At the 15th hour I was taken to the Emergency Department and received several liters of intravenous fluid.

As my difficulties increased, my need for medical support increased as well. In the middle of the night I found myself surrounded by three physicians and two advanced practice nurses, none of whom were scheduled to be at the pool at the hour when my need was greatest. When it became all too apparent that I had gone beyond the point where the situation could be salvaged, they arranged for my visit to the hospital. One of them, a psychiatrist and a good friend, accompanied me and stayed with me until my treatment was complete. Michael, Sally, Mary, Lanie, Karin, and Jeff were grace.

And during my struggles, Claire quietly kept on swimming. She was a machine. She maintained an amazing focus and successfully completed all 24 hours of the marathon. She was able to keep herself fed and watered properly, and she had an hourly ritual during each break that allowed her to maintain her drive and prepare the next hour. Her body maintained its stamina throughout and she finished the project for us, to the cheers of the crowd. Claire was also grace.

Later, one of the ovarian cancer survivors handed me a card. In it she had written the following expert advice: “Sometimes things don't work out as you had planned. Barriers are thrown in your way. So you just learn to accept the barriers.” For me, accepting the barriers made it possible for me to receive the love and care I so desperately needed. Those words of encouragement were grace.

When I was being taken to the hospital, a number of people tried to comfort me about not being able to meet our goal. As we walked toward the door I suddenly realized that the pool had four swimmers at 3 a.m. There were volunteers everywhere. There were medical support people by my side, even though they were not scheduled to be with us at 3 a.m. I remembered that I had prayed for grace and realized, at that moment, that I had really been praying to be able to complete this goal by myself. But grace came in the form of multiple champions, equally invested in the goal and generously giving of their time and effort. This wasn’t a failure. This was a victory, and I was overcome with gratitude.

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Religious participation encourages father involvement

By Richard J. Petts

Becoming a parent dramatically changes one’s life. Having a child may have an especially profound effect on men’s lives, leading men to settle down, reevaluate their priorities in life, and become more committed to their families (Snarey 1993; Wilcox 2002). However, facing these challenges can be difficult. Many men have no experience in raising children, causing new fathers to search outside sources for parenting support and guidance on how to become a good father. One important resource available to new fathers is religion, and chaplains are in a unique position to help provide the support that new fathers may be looking for.

My research suggests that many men increase their involvement in religion after the birth of a new child (Petts 2007). New fathers may turn to religion in order to find meaning and significance in this life event. Fathers may also rely on religious institutions for guidance in raising children, and this guidance may be especially important for men who are having their first child. Because religious institutions and families are interdependent on one another, churches are often a primary source of support for new parents, and religious leaders should continue to focus on ministries that help new parents to be involved in their children’s lives.

Results from my study also suggest that attending religious services is linked to higher levels of father involvement (Petts 2007). Religious teachings may prepare men for the responsibility of raising a child and help them to find meaning and purpose in this life event. Religious involvement appears to be especially important for first-time fathers, who may be more reliant on churches to help compensate for their lack of experience in raising a child. In contrast, men who stop attending religious services or attend religious services less frequently after the birth of a child are less likely to be highly engaged in their children’s lives. Overall, these findings suggest that religious participation may help to promote parent-child interaction and involvement, and perhaps improve overall family cohesion.

By being available to new parents throughout the time of pregnancy and childbirth, chaplains have a great opportunity to provide the religious support that fathers may be looking for. Scholars argue that parenthood may increase one’s desire to turn to religion even if they were not religious prior to having a child (Berman 1968). Therefore, chaplains should strive to make themselves available and open to providing religious teaching and guidance to individuals who are making the transition to parenthood.

Support from chaplains may be especially important for underprivileged populations. My study was conducted among urban parents, a population characterized as having high rates of out-of-wedlock births and relatively low levels of income. These individuals likely do not have access to the same pre- and post-natal resources as wealthier parents, making them more likely to turn to free sources of support such as religious institutions. Because exposure to religion seems to play an important role in encouraging parents to become involved in their children’s lives, it is essential that chaplains extend a willingness to help and support men in these areas who may be seeking out religion for guidance in raising children and dealing with this major life change.

Exposing new parents to religion and encouraging them to become involved in a religious community may have a profound effect on children. High rates of divorce, non-marital cohabitation, and single parenthood (especially among poor and minority populations) leave many children at a disadvantage because they are not able to receive social and economic support from two parents. Since religious participation appears to increase the likelihood that fathers become involved in their children’s lives, getting new fathers involved in religion from the start may help to counteract some of the problems facing many American families today.

By helping new fathers find meaning and importance in parenthood, chaplains may be able to encourage fathers to develop stronger family commitments and increase the likelihood that they provide support to their children. Research suggests that even among nonresident fathers, interaction with children increases the likelihood that fathers provide vital social and financial support to children. Moreover, fathers who are involved early on in their children’s lives are more likely to stay involved as their children get older (Aldous, Mulligan, and Bjarnason 1998). Thus, chaplains may be able to (a) indirectly increase the financial well-being of disadvantaged families by providing religious guidance and support to new fathers; and (b) increase the likelihood that fathers remain engaged with their children throughout their lives.

It is important to note, however, that simply identifying with a religious denomination may not provide the same benefits as active religious involvement. Therefore, chaplains should not only provide religious support to new fathers, but should also actively encourage them to get involved in a religious community. Active participation in religious services may provide new fathers with a sense of community and social support, which may increase family commitments. In addition, religious institutions encourage families to attend services together as well as provide programs and resources to aid in child-rearing. Being immersed in such an environment may allow new fathers to become more effective parents, which may ultimately improve the well-being of parents, children, and families.

Overall, my research on the influence of religion on new
fathers has important implications for chaplains. Religious participation is associated with higher levels of father involvement, and many new fathers increase their religious involvement after the birth of a new child. Chaplains should be aware of the questions and struggles that men may have when becoming a new father and make an effort to provide religious support to men who are making this transition. Chaplains should also encourage new fathers to become active in a religious community as a way to gain increased religious support as well as learn about child-rearing practices and ways to pass on religious traditions to children.

One effective strategy may be to establish partnerships with local churches to assist in supporting new fathers. Such partnerships may help to ease the transition of shifting from a one-on-one support system between a chaplain and a new father to a community-based social support system within a religious community. Perhaps most importantly, increasing fathers’ religious involvement may help to improve family stability and cohesion, increasing the likelihood that children are raised by two parents (regardless of whether the parents live together). Chaplains may be able to play a primary role in fostering this religious involvement because of their accessibility to fathers at the time of childbirth, and should make themselves available to new fathers who are searching for religious guidance and support.

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References

Alan Bowman prays, learns, celebrates with NACC

**Name:** Alan E. Bowman  
**Work:** Catholic Health Initiatives, Vice President, Mission Integration.  
**NACC member since:** 1985  
**Volunteer service:** Board of Directors, Standards and Certification commissions; regional and national conference presenter; conference planning; USCCB/CCA Board as well as with APC and ACPE roles. Volunteering is always an opportunity for me to give back to the organizations and members who have blessed my ministry.  
**Book on your nightstand:** *Thomas Merton: Spiritual Master* edited by Lawrence Cunningham, and *The 101 Dalmatians* by Dodie Smith to read with my daughter.  
**Book you recommend most often:** *The Wounded Healer* by Henri Nouwen and *Good Grief* by Granger Westberg  
**Favorite spiritual resource:** Centering prayer and nature hikes  
**Favorite movie:** watching *Wild Hogs* with family and friends  
**Favorite retreat spot:** Rocky Mountains National Park  
**Favorite fun self-care activity:** Riding a motorcycle in the Rocky Mountains, enjoying the beauty of God’s creation  
**Personal mentor or role model:** Fr. Jerry Broccolo and Rev. David Middleton  
**Famous/historic mentor or role model:** Henri Nouwen  
**Why did you become a chaplain?** My grandfather and uncle both died from cancer, and I was searching for understanding and desired to learn more about how God journeys with those who are suffering.  
**Why do you stay with the NACC?** NACC is a very important part of my professional networking. It is where I enjoy opportunities to pray, learn, celebrate, and contribute with others who are committed to compassionate and professional caregiving.  
**Why do you volunteer?** It truly is in giving that we receive. When I volunteer with NACC, I not only enjoy the opportunity to share what I have learned with others, I also enjoyed the opportunity to learn with and from those who volunteer with me. I have developed relationships with people who are kindred spirits on this journey to open ourselves more fully to God’s presence and to invite others to join us on the journey.  
**What volunteer activity has been most rewarding?** Each volunteer activity builds upon prior experiences and expands my understanding and appreciation for the healing ministry. Serving on Certification encourages my hope for the future of NACC as I see talented, compassionate and diverse professionals join NACC. Serving on the Board broadens my appreciation for the diversity of ministries and services that NACC comprises. Serving on Standards renews my respect for professional criteria in preparing those who will serve the ill and suffering. Offering workshops deepens my understanding and appreciation for those who are dedicated to education and formation. All of the volunteer activities within NACC facilitate opportunities to build lasting relationships with others who share a belief and commitment to the healing ministry that we offer on behalf of the Church and for the sake of God’s people.
Study finds stages of families in medical crisis

By Lawrence VandeCreek

Chaplains provide ministry to family members of patients. The family members of those admitted with critical injuries or illnesses merit special attention, because these experiences leave a lasting impact. But how, exactly, can that experience be characterized? If chaplains and parish clergy knew that, they could more deliberately tailor their care. That was the purpose of the research article described here.

The author of this study invited family members to provide an in-depth description of their feelings and thoughts some months after the experience. She taped their descriptions, beginning the session by saying, “Would you please describe for me the experience of having your family member admitted to the hospital suddenly during a medical emergency in as much detail as you can remember?” She then simply let the family member talk. After transcribing the interview, she read and reread the material until the essence of that experience was clear. The author continued to interview family members of other patients until no new characteristics central to the experience emerged from the narratives. This required interviews with a family member of six patients, and each is briefly described in the article.

What were the results? In general, the “roller-coaster ride” metaphor described the experience. What participants described great ups and downs, no control over a terrifying experience, and the recognition that they had no choice but to wait until the ride ended on its own. Ten themes emerged from the narratives that described this ride.

Theme 1: The inability to feel. Shortly after they arrived at the hospital, participants felt that the experience was unreal. One said, “I was numb” and another stated, “My mind was very muddled.” This, however, soon ended.

Theme 2: Terrified waiting. Thoughts and feelings soon returned. Waiting, worrying was all there was to do. One stated, “All I could do was sit there with my thoughts. It was horrible. There was nothing I could do except sit there.”

Theme 3: Understanding the unspoken. The family members all understood more than what hospital personnel said to them. One said, “I could see it. I knew something was wrong. No matter what they said, after I saw the look on their faces, they couldn’t make me feel better.”

Theme 4: Controlled information seeking. Some family members wanted no information; others wanted a very controlled amount and type of information. One said, “When the doctor started listing all the operations that they had to do and what he was going to have to go though, I was very upset. … I think the details scared me.”

Theme 5: Protecting others. Participants protected others, primarily children and the patients, from what they were experiencing. One said, “So for the kids, I always tried to be positive.” Another stated, “I would schedule my cries.”

Theme 6: Isolated and alone. The participants were aware that they alone were experiencing these intense feelings. One said, “It’s like you are driving along the highway … with everybody else, and then (someone) tells you to get off at the next exit … and now you are all alone on a road by yourself, with no funds, no lights, no nothing.”

Theme 7: The busy mode. Participants sought relief by staying busy. “I needed to rake, so I raked acorns. I raked thousands of acorns … My house gets very clean and my yard gets very acorn-free.”

Theme 8: Fighting the system. Participants recalled struggling with bills. One said, “Green is the issue, and no one is colorblind.”

Theme 9: The saturation point. Each participant described the physical and emotional toll of the experience. One said, “I reached the saturation point after about three months, and I started taking medication for anxiety and depression.”

Theme 10: A new normal. Each became aware that there was no return to the old status quo. One said, “You have to establish a new normal and you have to live with the fact that there is a new normal.”

The author discusses nursing implications of these findings. However, chaplains will have little difficulty in drawing conclusions relevant to their ministry.


Larry VandeCreek, BCC, is a retired APC chaplain living in Bozeman, MT. This article originally appeared in the APC News.

Prayers for Healing

If you know of an association member who is ill and needs prayer, please request permission of the person to submit their name, illness, and city and state, and send the information to the Vision editor at the national office. You may also send in a prayer request for yourself. Names may be reposted if there is a continuing need.

Ellen Radday
Arlington, VA
Head injury
Summit identifies goals for future of pastoral care

By David Lichter, D.Min.
Executive Director

In the early months of 2007, the NACC and Catholic Health Association, under the leadership of Rev. Tom Landry for NACC and Brian Yanofchick of CHA, began to plan a Pastoral Care Summit. The goals were ambitious, but vital to the profession of pastoral care: to establish a vision, benchmarks, standards, and metrics to measure effectiveness of pastoral programs with the healthcare industry.

While NACC and CHA co-sponsored the event, Alegent Health in Omaha was the gracious host when we gathered Oct. 22-24. They also enlisted Right Track services for the Decision Accelerator process with Stu Winby as leader, facilitator and process designer for the Decision Accelerator Process.

For those not familiar with Decision Accelerator and the Right Track facility, the process is an intensive collaborative activity designed to “accelerate” the group's thinking, planning, and decision-making. Along with Stu, Christopher Fullerton was the graphic designer, capturing and synthesizing the content with key words, images, phrases, and themes on white walls. He was masterful in helping us visualize what we were discussing and advancing our work. Other support staff transcribed conversation and photographed whiteboards and our groupings. At the end of the planning, Right Track created a website for the content of the summit. CHA and NACC then further transcribed the photographed whiteboards.

The invitation list included representatives from senior leadership in Catholic health systems, including mission integration executives, experienced practitioners (chaplains and directors of pastoral care), the Spiritual Care Collaborative, researchers, measurement specialists, graduate programs in ministry, and ecclesial leaders. More than 100 invitations were sent out. Our working group was more than 50, but many who could not participate due to prior commitments want to be part of the follow-up activity. Those who participated are committed to see the process through.

We spent some initial time mapping out past and future influences on the pastoral care environment. Participants approached a whiteboard and added their wisdom to map. The group noted several future marks such as: professional standards of practice, more accountability, more distance learning and technology to train supervisors, leadership competencies, ethics expertise, research and publication, and resource sharing.

The group then divided into diverse perspective groups and looked at various articles to offer us some “best practice” information on the field of pastoral care. Each of us read an article or two, then shared the highlights to broaden our knowledge base.

This all led us to the exercise of envisioning a best practice 2017 vision of pastoral care in healthcare. We had to articulate a storyline for a particular publication, whether Health Progress, Modern Health Care, USA Today, The New York Times, or others. This was an inventive exercise that helped us express where pastoral care and chaplaincy needed to go. We ended day one both tired and enlivened, with an overview, big picture of pastoral care and chaplaincy. Now we were anxious to get working on outcomes.

On day two, we self-selected our groups based on our interest: educational tracts/credentialing, staff development/composition, recruitment, metrics, care services, information technology resources, and financial resources. Each group identified the key components of its respective area. Then one person presented the work to the other participants and sought further insights from them as they migrated from group to group. This added further depth to the work.

The groups were then asked to further refine the results and generate both a short-term and long-term (three-to five-year horizon) action plan with milestones. On the final morning, we further refined and shared the action plans, and created a comprehensive overview.

This was a first-of-its-kind activity for our profession, as we had representatives from so many systems and hospitals. Do we have a vision? We have the beginning of a shared vision that will need to be further tested and refined in our diverse settings.

Do we have benchmarks? Many diverse benchmarks were identified. However, we have follow-up work to summarize and prioritize them.

Do we have standards? Many systems have standards for pastoral care; some do not. We sensed a commitment on participants’ part to share what they have and to work toward some common standards in collaboration with the Spiritual Care Collaborative, but we do not want to reinvent the wheel. It would be best for all if systems with established standards make their work available as a baseline for developing common standards.

Do we have metrics to measure effectiveness of pastoral programs within the healthcare industry? The metrics group strove to develop a question that could be used in healthcare surveys, such as Press Ganey. These groups took the initiative to self-organize and committed to a series of monthly meetings to identify these metrics.

So, did we achieve the objectives? I believe every participant was disappointed that we did not get as far as we had anticipated. However, everyone left committed to continue the important work that was begun. As one participant expressed it, “We can’t do this alone or as isolated systems. We have to do this together.”

Yes, the steaks are good in Omaha. However, the stakes were high at this summit, and they remain high. Participants from healthcare systems invested tremendous human and financial resources into those days. NACC and CHA are committed to see that the objectives of this summit will be met.
WHO are we called to be as pastoral and certified chaplains within the Roman Catholic Church? What are the challenges we face in relating to the wider Church in this day and time? How do we bring our many gifts and talents to the service of the whole Church? How do we support each other as NACC members in the ongoing issues that we face?

These are some of the questions that the 2008 NACC National Conference Planning Committee had to work through during our teleconference meetings last fall. As a first-time participant in an NACC national conference planning session, I listened intently to those more experienced. It felt similar to my experience as a pastoral musician — in that role, I have had to become adept at reflecting on the readings of a given Sunday, then looking for hymns and songs that interpret and enhance those readings. In much the same way, while issues were being raised, the song “Sing a New Church” began to come to mind, especially the beginning words of the refrain: “Let us bring the gifts that differ, and in splendid varied ways, sing a new Church into being...” It seemed to resonate with the group, and, ultimately, we fine-tuned the words into our Conference theme.

Very real challenges confront many of us in our hospitals, prisons and other places of ministry. In the midst of the graced moments and challenges of our ministry, we recognize not only the diversity of our own many splendid gifts as chaplains, but that we work amidst remarkable co-workers and within a larger church enriched by diverse roles and gifts.

No three- or four-day conference can solve the major issues facing us. But we can support each other in “splendid varied ways,” and that is our hope for the 2008 conference. We want to look at our ministries as both GIFT and CHALLENGE, and nationally known speakers will be addressing four key questions in our plenary sessions:

- Rev. Kenan B. Osborne, OFM, will speak to: How is our sacramental life a gift and foundation to our ministry?
- Rev. Richard M. Gula, SS, will address: In light of Catholic values and ethics, what gifts and responsibilities do we bring to our ministry that are unique?
- Carolyn Osiek, Ph.D., will offer her thoughts on: In light of our ministry, what does Scripture teach us about our prophetic calling?
- Sr. Jamie T. Phelps, OP, will discuss: Where are we being challenged to grow in our ministry?

Again this year, many different workshops will be offered. Committee members have suggested a number of different topics, such as clinical ethics, mental health, diversity, outcomes, palliative care, end-of-life decision making, mission services and pastoral care, pediatric care, spirituality, basic teaching and presentation skills, promoting and marketing pastoral care and ourselves, to name a few.

One very significant decision made by the Planning Committee is to create a separate time during the 2008 Conference for NACC workshops (e.g. certification or interviewer training) to leave members free to attend other workshops.

I have been given the responsibility of preparing and leading the music for the 2008 Conference. I am grateful for this opportunity, as it blends my ministry as a board-certified chaplain over the past twelve years and my ministry in music over the past 40 years. I am looking forward to providing very joyful, hope-filled music of the Easter season during our Eucharistic celebrations and prayer services, and quietly prayerful music when we gather for our Taizé-style healing service.

Come and join us on April 5 through 8, 2008, in my home town of Indianapolis, IN. Let us all come together with our many different gifts and talents to support one another in ministry “in splendid varied ways!”

Carey Landry, BCC, is a chaplain at St. Vincent Indianapolis Hospital in Indiana. jclandr y@stvincent.org
Art Metallo, Ira Byock to be honored at conference

A distinguished member and a distinguished friend of the NACC will be honored at our conference in Indianapolis this spring, as the association reinstates the practice of annual awards after a seven-year lapse.

Ira Byock, MD, will be honored with the Outstanding Colleague Award, given to a person or group outside the NACC who supports the NACC or the field of ministry, and Deacon Arthur Metallo has been selected to receive the NACC’s Distinguished Service Award.

Ira Byock is the chair of palliative medicine at Dartmouth-Hitchcock Medical Center; and a professor in the departments of anesthesiology and community and family medicine.

He has been involved in hospice and palliative care since his residency in 1978, when he helped found a hospice home care program for the indigent population of Fresno, CA. He is a past president (1997) of the American Academy of Hospice and Palliative Medicine. During the 1990s he was a co-founder and principal investigator for the Missoula Demonstration Project, a community-based organization in Montana dedicated to researching and transforming the end-of-life experience locally, as a demonstration of what is possible nationally. From 1996 through 2006, he served as Director for Promoting Excellence in End-of-Life Care, a national grant program of the Robert Wood Johnson Foundation.

Dr. Byock has authored numerous articles on the ethics and practice of hospice, palliative and end-of-life care. His first book, Dying Well, has become a standard in the field. He has been an advocate for the voice and rights of dying patients and their families. His most recent book, The Four Things That Matter Most, (2004) is published by the Free Press.

Dr. Byock has received the National Hospice Organization’s Person of the Year (1995), the National Coalition of Cancer Survivorship’s Natalie Davis Spingarn Writers Award (2000), and the American College of CHEST Physicians Roger Bone Memorial Lecture Award (2003). He has appeared on numerous national television and radio programs, including NPR’s All Things Considered and Fresh Air, ABC’s Nightline, CBS’s 60 Minutes, and PBS’s The News Hour.

Deacon Art Metallo recently retired from Resurrection Health Care in Chicago, where over 100 chaplains and CPE interns and residents throughout the system considered him their servant leader. Besides chaplains, he ably related to volunteers, staff, administrators, patients, CPE residents and interns, clergy, and bishops.

Deacon Metallo was born in Chicago and holds degrees from Mundelein College and Loyola University. While working as a supervisor for Jewel Food Stores, he was ordained to the diaconate in 1974, and shortly afterward became a chaplain at St. Francis Hospital in Evanston, IL. Following Resurrection Health Care’s purchase of St. Francis, Deacon Metallo became director of spiritual services in 1998.

In managing chaplains of various denominations and faiths, he showed respect for diversity and ecumenism, while at the same time modeling the Catholic values. Because of his encouragement, many chaplains became certified by the NACC and/or the APC.

He initiated and developed the RHC system-wide CPE program.

Art also developed a system-wide spiritual services operational policy manual for staff and helped to integrate and standardize spiritual services in all venues: acute care, long-term care, retirement communities, behavioral health, home health and hospice care in a system that ministers to over 105,000 acute care patients, 265,000 emergency room patients, 4,600 nursing home residents, and 1,400 retirement community residents each year.

Art justified chaplain FTEs by applying mission standards as well as metrics. He made sure the chaplains were part of the leadership team at each facility. His passion for the mission showed itself in his concern for providing the spiritual component of healthcare.

Deacon Metallo retired from Resurrection last fall. He lives in Chicago and in Chandler, AZ, and has three children and six (soon to be seven) grandchildren.

Solace

By Deborah Gordon Cooper

And still, the world goes on being beautiful… the trees, the water and the sky offering solace, whether we see or not.

Just now, the clouds behind the black limbs of the mountain ash catch fire in the last light of the day.

Hope rings in the delicate throat of a single bird, singing the sun down, whether we’re listening or not.

Even as we sleep the gracious moon traces the sky, keeping the night-watch… soft spill of light across the bed.

Deborah Gordon Cooper, BCC, is a chaplain emerita in Duluth, MN.
Chaplains help the team assess spiritual distress

By Michele Le Doux Sakurai

“The patient is a pastor and has lots of support; he won’t be needing a chaplain.” Karen, an experienced nurse, was reporting her observations to me; Pastor Smith had had visits from family members, church members, and clergy friends throughout the day. I trusted Karen’s clinical skills and her intuition; Pastor Smith became a low priority for my visits that evening. It was a busy shift, and I gave no thought to him until his wife stopped me in the hall: “You’re the chaplain, aren’t you? Please, could you stop by to see my husband? But wait until all his visitors are gone.”

I saw him at 9 p.m., and he welcomed me. “I am so glad you came by; I really need to talk to someone. You see, I have two small children, and my treatment isn’t going well. I don’t believe I will survive this cancer, and I am struggling with where God is. I know my family and friends are trying to be encouraging as they talk about God’s healing presence, but that is not what I am feeling. This is so hard for me. I thought I had faith, but now, I just don’t know. … I’m a pastor, and to speak of such doubts could undermine the faith of my community. I don’t dare speak of such things even to my clergy friends. I don’t know where to turn.”

Pastor Smith’s dilemma isn’t unique; this is actually just what chaplains are trained to handle. After four or more units of CPE, we develop the skills to recognize spiritual distress. A chaplain visiting with this patient, while friends and family were present, might have recognized a disconnect between the faith sentiments of friends and the response of Pastor Smith (for instance, lack of verbal response, eye contact, engagement, or nonverbal responses that would have indicated his spiritual distress). To see such a disconnect not only takes training, but it also requires time. Even if trained, most nurses do not have the luxury of time at the bedside for such assessment. Many nurses, and other interdisciplinary team members, find spiritual assessment to be outside their expertise. Providing team members with examples of spiritual distress is one way to help them to more easily recognize when this is a problem for patients or their families.

Perhaps the most familiar indicator of spiritual distress comes in the form of a WHY question, “Why is this happening to me?” or “Why does God let this happen?” A patient or family member asking “Why” generally is looking less for an answer and more for someone to hear their pain and suffering. To be present in this manner requires time with no interruptions and the discipline to hear the anguish without needing to fix the dilemma.

When the “Why” question is not adequately addressed, a feeling of alienation from God/Higher Power can result. Such alienation can exhibit as anger, “I want nothing to do with God,” or “I can’t believe in a God who would let this happen!” or “I’m too angry to pray.” Alienation can also be experience through a sense of guilt: “Am I being punished?” “Some things God can’t forgive.”

For some patients, the religious authorities have not adequately addressed issues of crisis. Such examples include, “My pastor says if I had enough faith, I wouldn’t be in this mess.” “The pastor says I am paralyzed because of something wrong I did early in life.” “My husband says if I divorce him, I will go to hell.” “My pastor says my wife is dying because I haven’t saved enough souls for Jesus.”

In our social context, extended families are no longer the norm. People move more, and connection with church can become fragmented. Examples of such fragmentation include: “I got sick and was moved into foster care; I haven’t been to church or seen my pastor for a long time.” “My pastor of 18 years has retired, and I just don’t care for the new one.” “It’s been so long; I don’t know how to pray anymore.”

Often times crisis can trigger unresolved issues: “This is the third family member to die this year,” or “I thought I was over my dad’s death, but it’s all coming back.” Crisis can also cause unresolved conflicts to surface, “I’m estranged from my family; I have no one;” (son to dying father) “You did this to yourself; it serves you right!” “My daughter lives out of state, but I don’t want to bother her;” “My father can’t die without accepting Jesus as his Savior.”

In the clinical setting, religion can become a barrier to a plan of care. For instance, patients who refuse pain medication because “I need to suffer to get to heaven.” Or sometimes patients or family members use religious reasoning to continue heroics when heroics are futile: “I know my mother wouldn’t want to live like this, but in good conscience, I can’t just let her go,” or “I believe in miracles.”

In essence, spiritual distress can be manifested in a variety of ways; as anger, fear, confusion, grief, anxiety, depression, despair, desperation, or religious entrenchment. The questions or statements need not be religious in nature. “Is it a sin to want to die?” sounds religious, while “I’m tired of living” does not. Yet both reflect deeply spiritual issues of despair. Helping staff to listen on a deeper level can increase their appreciation of spiritual care’s complexity, as well as of chaplains’ distinctive skills, and hopefully increase referrals to chaplains.
By Nicole Onori Hansen

On behalf of the Pregnancy Loss Support Group, my husband Jay, son Evan, and I would like to invite you to share in this time of remembrance, healing, and hope.

Our journey began unexpectedly almost 14 years ago on February 27, 1994. On that day, our son Gabriel was born prematurely and died in my arms.

On that day, I wept with profound heartache.
On that day, an abysmal grief engulfed my soul.
On that day, we became parents, a mother and a father.
On that day, our family was created.
On that day, I touched life and death.
On that day, I asked God, why?

There are mothers and fathers here today for whom the grief of pregnancy loss is as new as it was for me on February 27, 1994. There are others, like myself, who became intimate with this loss many years ago. For me, the crushing grief and anguish eventually became like an old friend who slowly drifted away. Yet it was not until I fully surrendered myself to the throes of its pain and profoundly experienced my own humanness through its suffering, that grief began to gradually distance itself from me. Once in a while, I still intentionally choose to visit it, or it unexpectedly visits me because it is a part of who I am.

I still do not understand why. I no longer seek the answer to that futile question. Instead, I have chosen to embrace the gift of a son who has taught me about the blessings of faith, hope, love, and compassion. It is through remembering and loving Gabriel that I have found the true meaning of these blessings and the path toward healing which has let me set my grief free. My hope is that, in your own way and in your own time, you find blessings and meaning in your journey from grief to healing.

Through miscarriage, infant loss, and stillbirth, grief has been a companion to all of us. Grief — that raw, almost inhumane, unbearable emotion that defies expression has drawn us together today as a community. Today, our silent suffering may be openly expressed, shared, and understood in the refuge of this safe, accepting community of family and friends — family and friends who have chosen to accompany us on our journey through grief toward hope and healing. We are blessed to have this community and this time and place to remember.

Nicole Onori Hansen is an occupational therapist, writer, and life/wellness coach in Rochester, MN. This article is adapted from a reflection given at the annual “Remembering” Service on Oct. 28, 2007, sponsored by the Mayo Pregnancy Loss Support Group in Rochester.

Ultimately, we as chaplains are the ones who must educate staff regarding what competent spiritual care entails. All spiritual care requires a sensitivity to professional and personal boundaries. One of a chaplain’s roles is to articulate to staff what these boundaries entail, while at the same time honoring the gifts that staff members bring to the bedside - for indeed, spiritual care is a shared ministry.

Michele Le Doux Sakurai, D.Min., BCC, is Trinity Health System’s 2007-08 mission fellow in Boise, ID. MICHSAKU@sarmc.org

When should the chaplain be called in?

Even when interdisciplinary team members are skilled and feel comfortable addressing the spiritual distress of their patients, in some situations a referral to a chaplain will be critical. They include:

• When the patient’s question/story begins to feel overwhelming to the staff member.
• When a staff member begins to feel “hooked” or wants to “fix” the spiritual issues.
• When time constraints do not permit the team member to fully address the spiritual issues.
• When staff (nurse, OT/PT, social worker) must wear the hat of their profession.
• When the staff member has evidenced anger/frustration with the patient or has judged the patient (“impossible,” “non-compliant,” “druggy,” “demanding,” etc.)
• When the patient’s theology seems alien to the staff member’s understanding (could be cultural, religious, or personal interpretation).
• When a team member thinks s/he knows the answer to a patient’s question of meaning. (Such certainty can be dangerous and give way to religious or secular proselytizing.)
• When the patient’s faith community and the patient’s experience are in conflict.
• When the patient expresses sense of abandonment by God, community, or clergy.
• When intuition tells the staff member that something is amiss, but it isn't easily identifiable.
Positions Available

▼ HOSPITAL CHAPLAINS
San Bernardino, CA – The Diocese of San Bernardino, the 10th largest diocese in the US, is seeking highly motivated Catholic priest chaplains for various hospital sites in sunny Southern California. Positions are full-time and include a generous salary and compensation package (salary, paid medical and automobile insurance, retreat allowance). Some positions also include very comfortable housing provided by the Diocese of San Bernardino. Bilingual skills are very much needed (English/Spanish). CPE training is highly preferred. Priests must be in good standing with their respective arch/dioceses and/or religious communities. We are a growing multicultural diocese based on the vision of hope and healing for the Catholic people of the Inland Empire. Send inquiries and resumes to: Rev. Msgr. Gerard M. Lopez, Diocese of San Bernardino, 1201 E. Highland Ave., San Bernardino, CA 92404-4641. Telephone: (909) 475-5123.

▼ DIRECTOR OF SPIRITUAL CARE
Los Angeles, CA – In accordance with the mission and philosophy of the Daughters of Charity, St. Vincent Medical Center seeks a Director/Priest to provide living evidence of Christ’s healing love and ministry to the spiritual, religious and pastoral care philosophy and practice. For more information about the Diocese of San Bernardino. Bilingual skills are very much needed (English/Spanish). CPE training is highly preferred. Priests must be in good standing with their respective arch/dioceses and/or religious communities. We are a growing multicultural diocese based on the vision of hope and healing for the Catholic people of the Inland Empire. Send inquiries and resumes to: Rev. Msgr. Gerard M. Lopez, Diocese of San Bernardino, 1201 E. Highland Ave., San Bernardino, CA 92404-4641. Telephone: (909) 475-5123.

▼ CHAPLAIN
South Bend, IN – Saint Joseph Regional Medical Center is a faith-based, Catholic hospital providing inclusive interfaith pastoral care to a wide variety of persons. We have six staff chaplains across three sites and a well-developed ethics committee. The department maintains a strong ACPE program. South Bend, home of the University of Notre Dame, offers a community atmosphere with advantages of a larger city. We are looking for an individual for our full-time position who has a vision for the opportunities this ministry provides to staff and patients. We are looking for an individual who can be flexible in their schedule as we move to a new hospital in two years and develop new services. We need a person who has a well-developed sense of the role of professional chaplain and can help us move toward a more outcome-based pastoral care. M.Div. preferred, master’s in related field considered. Four units of CPE (residency preferred), certification by APC or NACC or eligible within two years, and computer proficient. For consideration, please submit an online application at www.svmedicalcenter.com. Please email your resume to: sylviacolvin@dochs.org or apply online. EOE.

▼ DIRECTOR OF CATHOLIC HOSPITAL MINISTRIES
Columbia, MO – The director is responsible for planning, organizing, coordinating and directing the activities of Columbia Catholic Hospital Ministries. Columbia Catholic Hospital Ministries offers spiritually based clinically trained pastoral care and counseling through sacramental ministry and spiritual/emotional support to the Catholic patients and their families in the hospitals in Columbia, MO, M.A. in theology, psychology, counseling, or their equivalent is preferred. Certification as a chaplain by the NACC, or experience and eligible for certification by NACC. Commissioned as an extraordinary minister of the Eucharist. Knowledge of medical moral theology and ethics. At least three years of healthcare experience as chaplain or director. Salary depending on qualifications; negotiable. Send resume to Ron Vessell, Diocese of Jefferson City, PO Box 104900, Jefferson City, MO 65110; telephone (573) 635-9127; fax (573) 635-2286.

▼ DIRECTOR OF PASTORAL CARE
Suffern, NY – Good Samaritan Hospital, a member of the Bon Secours Charity Health System, is a community-based Catholic hospital dedicated to caring for the whole person, body, mind, and spirit. We are currently seeking a board-certified Roman Catholic chaplain who, with staff, leads a comprehensive program of pastoral care (sacramental and pastoral) for patients, families, staff and physicians. Qualified candidates must possess a bachelor’s degree in theology or related field; a master’s degree is preferred. CPE certification with two years of clinical pastoral experience in a healthcare setting is also preferred. This position has the possibility to become a CPE supervisory opportunity. To be considered for this position, please visit our website and apply online at www.bschs.org/careers. EOE.

The future of Positions Available

For as long as the NACC has had a publication, it has included job listings. Our readership is exactly the group that healthcare institutions want to reach when they need to hire a chaplain or a pastoral care director, and we’ve been happy to help employers and employees find each other.

In recent years, the Internet has become a more and more important way of looking for jobs and of filling jobs. We responded by adding Positions Available on our website, essentially duplicating the listings in Vision, and it has become one of our most-viewed areas.

But as media becomes more electronic, and as jobs are posted and filled more quickly, we have to assess whether Positions Available is still an efficient use of our ink and paper. Due to our publication lag time, at least a month, and often more, goes by between the time an employer submits an ad to us and the time you read it in the newsletter. The lag time for online posting is usually less than a week.

We have not yet made any decisions about the future of Positions Available, but we would like to hear your thoughts about the printed version and possible alternatives. Please write to David Lewellen, NACC, 5007 S. Howell Ave. Suite 120, Milwaukee, WI 53207, or e-mail dlewellen@nacc.org.
**DIRECTOR OF PASTORAL CARE**

_Provea St. Joseph Center_ seeks a Director of Pastoral Care. The Director is responsible for leadership in planning, implementing, supervising, and evaluating all pastoral services provided for the residents, their families and the employees. The Director reflects the organizational mission of the facility and the Church itself in providing an atmosphere of Christian concern and the dignity of each person. CPE or equivalent pastoral training/experience is required. Candidates must have a bachelor's degree in theology or related field and be certified by NACC. Send resume to: Roberta DeHaven, 659 E. Jefferson St., Freeport, IL 61032, phone (815) 232-6181, fax (815) 232-6143 or e-mail to roberta.dehaven@provena.org.

**PRIEST CHAPLAIN**

_Westport, CT_ – Hall-Brooke Behavioral Health Services, a 76-bed inpatient psychiatric hospital and a subsidiary of St. Vincent’s Health Services, is looking for a part-time priest chaplain. Responsibilities include providing for the spiritual needs of patients and families through sacramental coverage and participating in religious services as requested and appropriate. Experience in or interest in running spirituality groups for adults, adolescents and children on the units. Duties also include providing for the spiritual needs of Hall-Brooke staff, employees, volunteers and students, including monthly Mass for employees. Certification: Successful completion of 4 units (1,600 hours) of clinical pastoral education with certification by National Association of Catholic Chaplains (NACC) or certification eligible. Send resume to: Rev. ReBecca Sala, Coordinator of Pastoral Care, Hall-Brooke Behavioral Health Services, 47 Long Lots Road, Westport, CT 06880, Fax 203-341-4527, e-mail: rsa@stvincents.org. EOE. www.hallbrooke.org.

**CHAPLAIN**

_Miramar Beach, FL_ – Sacred Heart Hospital on the Emerald Coast, a 58-bed full-service community hospital, located east of Destin, FL on the Gulf Coast of Mexico, seeks a full-time staff Chaplain to assist the Director of Mission Integration/Pastoral Care in providing spiritual/pastoral care to patients, families, associates and volunteers. Sacred Heart Hospital on the Emerald Coast is part of Sacred Heart Health System and Ascension Health, the largest non-profit health care organization in the nation. Bachelor's degree in theology or related field is required; master's degree is preferred. Four units of CPE is preferred. NACC, APC or similar certification preferred. Experience in health care setting is preferred. Competitive benefit and salary package is available. Qualifed applicants may fax resumes to 850-278-3061 or submit an online application at www.sacredheartemerald.org. For more information, visit/apply at: www.providence.org/careers (Job #22929) or email Fiona.Gladden@providence.org.

**CPE RESIDENCY**

_Lubbock, TX_ – Covenant Health System residency positions beginning August 2008 through 2009. Application fee is $30; tuition is $250 per unit. Stipend is $24,600 plus benefits. University degree required. Seminary preferred. Covenant Health System is the largest healthcare institution in the region, with 1,383 licensed beds, 6,000 employees and more than 600 admitting physicians. Serving a 62-county area across west Texas and eastern New Mexico, with a population in excess of 1.3 million, Covenant Health System was created June 10, 1998, through the merger of Lubbock Methodist Hospital System and St. Mary Hospital. CPE at Covenant Health System provides students an opportunity to work as part of the healthcare team in offering holistic care. We offer CPE training opportunities in all major medical specialties. Applications may be submitted by mail along with the $30 application fee to Jan Kelley, Spiritual Care/CPE, Covenant Health System, 3615 19th Street, Lubbock, TX 79410. Inquiries may be made by phone on (806) 725-0604 or via e-mail to Jan Kelley, jkelley@covhs.org, or to the CPE Supervisor, Bob Powell, bpowell@covhs.org.

**BOARD-CERTIFIED CHAPLAIN**

_Spokane, WA_ – Sacred Heart Medical Center, 2 evenings/2 nights benefited position (32 hours per week, 64 hours per pay period). Qualifications include board certification with NACC or APC (or ability to be certified within 18 months of hire), master's degree in theology or related field, a minimum of four units of Clinical Pastoral Education, ecclesiastical endorsement. The successful candidate will be proficient in spiritual assessment, computer documentation, end of life care, and committed to working as a member of an interdisciplinary team. Prefer experience in an acute care/trauma setting. For more information or to apply, go to www.shmc.org.

**CHAPLAIN**

_Mt. Vernon, IL_ – The Mt. Vernon campus of St. Mary’s Good Samaritan Inc., a member of SSM Healthcare, seeks a Chaplain for its Pastoral Care Department. Primary responsibilities are to provide pastoral care to patients, families, and employees and other related duties as assigned. CPE required and must be certified by NACC or APC. Experience desired. Send resume to: Good Samaritan Regional Health Center, 605 N. 12th St., Mt. Vernon, IL 62864; attn: Human Resources.

**DIRECTOR, MISSION INTEGRATION**

_Hood River, OR_ – Providence Health & Services in Oregon, a nationally recognized, premier integrated health system, is seeking a Director of Mission Integration to assist the CEO in ensuring overall Mission Integration and Spiritual Care in the Gorge Service Area, and, in particular for Providence Hood River Memorial Hospital and other associated healthcare facilities. Requirements include two continuous years experience in pastoral/ministerial service beyond certification. Successful completion of four units CPE training or enrolled in a CPE program to complete the necessary four units. Certifiable by National Association of Catholic Chaplains (NACC) and/or Association of Professional Chaplains (APC). For more information, visit/apply at: www.providence.org/careers (Job #22929) or email Fiona.Gladden@providence.org.

Certified NACC chaplain, liturgist/musician, and spiritual director seeks a full-time position in spiritual care — in a hospital, retreat house, Catholic parish or college campus. Interested in the Denver, CO, area, or Ohio, West Virginia, Michigan, or Pennsylvania areas. Contact: Sr. Charlene Schaaf, CDP; rckymtncdp@hotmail.com or by phone, (303) 431-2309.
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February
15 Chaplain certification materials due at NACC office
18 Copy deadline, April Vision

March
8-12 APC annual conference, Pittsburgh, PA
17 Copy deadline, May Vision
21 National office closed for Good Friday
27-29 AAPC annual conference, Norfolk, VA

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