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NACC promotes awareness of chaplaincy's value

By David Lichter

When we considered devoting an issue of *Vision* to the value of chaplaincy, my first thought was, "Haven't we done that recently?" However, when going back to the *Vision* archives (www.nacc.org/vision/backissues.asp), we do not find the topic at all. (By the way, as I looked at the list of themes of the past five years, I was amazed at all we have covered! There are treasures there – pertinent and substantive!) The nearest topic was on the "awareness of chaplaincy" (www.nacc.org/vision/July_Aug_2010/default.asp) in July-August 2010, nearly four years ago, and the focus of that issue was more on promoting chaplaincy as a vocation! I realized the familiarity of the topic is because it has been top of mind of us for the past three years as a strategic priority.

Our Goal II of the 2012-2017 NACC Strategic Plan (www.nacc.org/docs/about/NACC-2012-2017-Strategic-Plan.pdf) is "to increase the awareness of the value of professional chaplaincy among key constituents." The three objectives focus on materials and programs; communicating current research on the value of chaplaincy; and partnering with associations and clinical research facilities to engage members in research. So, the timing of this *Vision* topic is opportune. While the articles in this *Vision* touch on various aspects of chaplaincy's value, I would like to highlight some of our efforts towards our Goal II.

Since I arrived at the NACC, the value of chaplaincy has been high priority. In October 2007 the CHA/NACC sponsored the Omaha Summit. Over 50 Catholic healthcare professionals, including chaplains, sought a consensus on metrics to determine the productivity and effectiveness of chaplaincy. The premise was and remains that we assert our value as we measure our effectiveness. A metrics task force was formed as a result of that summit, but could not arrive at a consensus. Yet efforts continue within the CHA Pastoral Care Advisory Committee to share leading practices on measuring quality, determining staffing, and communicating the value of chaplaincy.

In the May 12, 2008 issue of NACC Now, I reflected (www.nacc.org/advancing/default.aspx) on advocating for the profession, and offered six areas for consideration for the next five years, and (yikes!) that date passed last May! Two of them especially struck me (we continue our efforts!):

A more effective, persuasive way to:

- Answer the question "How do we know we are doing it?"
 - a. Show the "value add" of spiritual care by being able to demonstrate its worth through improved methods of measuring its effectiveness.
 - b. Chart activity in a way that aligns with and aids all members of the care team. (Standards 106.9, 305.5)
- A more widely cultivated professional mindset among spiritual care providers (Standard 305) that emphasizes:
 - c. A resolute dedication and ongoing commitment to improving one's gifts and competency for the sake of the patient/resident/client being served.
 - d. A willingness to "give away" the profession through open discussion and dialogue with, and teaching and mentoring of, other healthcare colleagues to understand what we do and outcomes we expect, rather than trying to hold onto our work under the aura of mystery or out of fear of being misunderstood.
 - e. An attitude that moves from "I am afraid of losing my job" to "I will get better at my job by training and delegating to others what I can in order to stay focused on the key aspects of my work, thus better serving our patients/residents/clients."

We have tried over the years to develop materials, but we continue to work on this. Hopefully you have clicked on the "Advancing Chaplaincy" icon on the homepage of our website (www.nacc.org/advancing/default.aspx) and then clicked "Ministry Awareness Materials" (www.nacc.org/advancing/promo.aspx) to find our video, PowerPoints, articles, elevator speeches, and other materials that might be useful to you. We will continue to add and update this material. I had a session of communicating the value of chaplaincy at the 2013 National Conference and on our June 2013 audio conference. But we have more to do.

What we have not done well yet is actually work individually with you to train you to speak about the profession in a passionate, professional, convincing way. We invited you in NACC Now during 2013 Pastoral Care Week (www.nacc.org/resources/e-news/nn-issue-157.aspx#13) to try to use elevator speeches from the NACC website, and also to share your elevator speeches about our ministry. We received two replies from members. Can it be because we do not

have one? What more can we do to assist with this? Please let me know.

Research is the topic of two of the three Goal II objectives. The March-April 2013 *Vision* (www.nacc.org/vision/Mar-Apr-2013/default.aspx) was dedicated to research, and there are excellent articles in that issue. The value of chaplaincy is being pursued through research professionals and our own chaplains. Most recently, March 31-April 3, 2014, HealthCare Chaplaincy Network sponsored a conference titled *Caring for the Human: Driving the Research Agenda for Spiritual Care in Health Care* (see www.healthcarechaplaincy.org/userimages/events/cfhs_2014/cfhs2014_brochure.pdf) that shared the results of six major research studies on spiritual care that represent the latest, most comprehensive body of research. Chaplains were part of each of the research teams. This is an exciting, promising, and important advance in research to advance the value of chaplaincy.

Our work continues, friends, as we seek ways to name and share the value of chaplaincy. Thank you for all you do to live the value daily in your ministry to the aging, ill, and dying and all your colleagues who work with you.

Blessings,

David A. Lichter, D.Min. Executive Director

The case for chaplaincy: If not me, then who?

By James J. Castello

So what's going on these days? Our economy is in the tank, and a record number of people are out of work – including many chaplains, as healthcare organizations slash their budgets to the bone. The cuts eventually come down to the Pastoral Care department where personnel salaries are 90% of the department's budget. So what can we do about this situation – what can each chaplain and spiritual care director do? The answer is plenty!

Each of us needs to develop a plan to educate everyone in our organization on the value of chaplains – our education, the roles we play, the gifts we bring to the organization and the real spiritual, emotional and financial contributions we make throughout the year. The challenge is to educate and communicate our worth clearly, using the language of the people we talk to. This exercise is often referred to as the elevator speech, which is a one-minute talk you could give if you found yourself on an elevator with your CEO or another professional in your organization. It's your chance to shine and really score points for our ministry. You can find this speech on the NACC website described below.

For example, when talking to **administrators** we need to show them the bottom-line impact of pastoral care in the organization. Studies show that good spiritual care by professional chaplains can improve patient satisfaction and referral scores. Chaplains also can keep the organization out of lawsuits by caring for and attending to very upset patients and family. A lawyer at a trauma center I worked for once told me that each lawsuit cost the hospital a million dollars, whether the suit is won or lost. Unfortunately, this is never captured in the financial statements of the organization, but I think it would be useful to document them.

When speaking to **clinicians**, it is essential to stress supporting the doctors' and nurses' patient-centered care. There are many ways to do this, but here are a few:

- Being a patient/family advocate by translating med-speak into terms they can comprehend after the shock wears off.
- Bringing hope to the hopeless and peace to the fearful.
- Calming patients, family and staff in chaotic situations by our presence and ability to listen to their stories, fears, emotions. A calmer patient and family make the medical care a lot easier.
- Taking the necessary time to explain to family members needing to make a very difficult life support withdrawal or withholding decision.

When speaking to **patients**, let them know we are here for them, to be present to them, to listen to them and to do our best to meet their spiritual needs. We do this as a representative of a God who loves them, and assure them they are never alone.

In talking to **family members**, we need to reassure them that we are there to support not only the patient but also the family. We can provide valuable services to the family by putting them in contact with the Ethics Committee when a moral issue is involved. Chaplain coordination of visits or reconnections by the patient's clergy can also be helpful and is always appreciated.

So here's what I think we need to do – we need to develop a specific plan for each spiritual care department with the goal of equipping each director and chaplain to be comfortable in making the case for the true value of chaplains. First of all, the plan needs a goal. Then the plan needs to clearly identify who we target to receive this communication over the next year. Next is to determine how we want to do this. There are a lot of tools available on the NACC website. On the home page is an excellent video on "Making a Difference in People's Lives." Also, here is a link to "the elevator speech" description as well as elevator speech resources and an incredible PowerPoint presentation on "How do we talk about our ministry," which provides really good scripts on how to talk to the primary people you work with and serve.

The NACC home office also has some helpful brochures they can send you or email to you. Ultimately, it's up to each of us to do all we can to educate people about our beloved ministry. In the last six months I have talked to a Knights of Columbus group, a men's faith-sharing group and a Legatus meeting on "What Chaplains Really Do" and "Death and Dying." The presentations were well received and elicited many questions. Each event occurred after I volunteered to speak on those subjects. I would suggest that we all look for opportunities to educate a wide variety of people on the worth of our ministry so that we are no longer the best-kept secret in the community.

It comes down to, "If not me, then who?"

James J. Castello, BCC, is an NACC board member and a retired chaplain living in Kennett Square, PA.

What we hold: Chaplaincy's ministry to institutions

By Bridget Deegan-Krause

Over the years I have listened to the many stories of the ways we as NACC chaplains tend to the needs of our institutions, with some in Catholic institutional ministry serving in the formal role of Mission Leader. Titled or not, most chaplains claim the care of their institutions as an integral part of their ministries. What we hold in our institutional care deserves a closer look as we consider the value of chaplaincy.

An extraordinary image of the apostle Paul from *The Saint John's Bible* comes to mind. In a pieta-like stance, Paul holds, with seeming tenderness, the shadowy but distinct forms of buildings. If we take a closer look at what Paul holds, we will see that these buildings are broken. [see the image at www.nacc.org/images/vision/J2hRPLIF.jpg]

I recently asked a group of ministers to reflect upon this image with a question: "What are you called to hold for your institution?" Their responses included the following: "I hold space." "I hold silence." "I hold pain." "I hold hope." "Sometimes I hold questions that do not yet have answers." "Sometimes I hold a torch."

Hard to Hold

This is a lot to hold, even for a strong chaplain. Our institutions can act in ways that are impersonal and self-serving. Human creations, so often broken and corruptible, our institutions let us down. Indeed, which one of us has not known pain and even death inflicted by institutions?

And yet institutions are what we have to sustain a common life. In his analysis of the contemporary church, *A People Adrift*, Peter Steinfels reminds us, "Even Jesus relied on institutions to announce his message and propel it into the world." When they are at their best, institutions express something of the Trinitarian God best known in relationship. Regina Bechtle, S.C., in her wonderful essay on the spirituality of institutions, asserts, "Organizations have a privileged role to play as partners in God's creative action in the world. Through them, God's dream of wholeness and right relationship for all creation can come closer to reality." As our salvation is somehow tied up in a communal enterprise (Revelation 22), we are called to look again to what is redeemable, and to help our institutions remember the bigger picture of which they are a part.

Holding our story

Perhaps the most important way that chaplains supportively hold their institutions is by helping institutions remember who they are. As chaplains we facilitate the holy act of remembering, with its rich scriptural mandate, any time we direct the attention of our colleagues to our foundational stories – the stories of sponsors, saints, unsung heroes, or any great shoulders we stand upon – and explicitly make a connection between where we come from, who we are and how we must act. This also happens in the holy work of calling attention to organizational "guiding behaviors" or "cultural attributes," of helping our organizations discuss a shared mission and vision, or exploring the gospel roots of the powerful value words we claim, like *reverence*, *stewardship*, or *justice*.

Some of our greatest work as chaplains is found in the efforts we make to help our institutions recognize themselves as part of a bigger story of living, dying and rising. We can help our organizations know they are held safe in the paschal mystery whenever we create a ritual to close a facility or tend a community through mergers and "rightsizing." Sometimes we simply hold hope, recognizing that the chaos of this moment is not the end of the story, nor does it constitute the whole of who we are as a people who participate in the healing ministry of Jesus.

A different kind of love

Most of us can easily make the case that the tender holding of a dying patient's hand is part of the healing mission of the institution. But where is the sacred to be found in the overhaul of an accounting system, or the careful crafting of an HR policy? The capacity for holding the bigger picture of organizational life has led some chaplains to develop administrative skills so they can expand the care they provide to include the management of resources, the solicitation of funds, and the crafting of curricula, work plans and websites.

Many chaplains claim the sacredness of this administrative side of their work, along with their efforts to develop their capacity to do it. In her work on the spirituality of administration, theologian Ann Garrido observes how the wide variety of tasks that are part of administration not only pose an intellectual challenge, but "can also be a spiritual exercise that stretches the heart, developing one's capacity for a different kind of love."

This different kind of love may move us closer to the paschal mystery in our work. There may be a dying to self not only as we submit ourselves to training programs or as we take on new responsibilities, but also as we venture into courageous conversations

within a corporate culture that has much that is broken and even deadly about it. Carefully timed questions become holy queries: "Who needs to be held accountable?" "What must we allow to die?" "Who is missing from this conversation?" "How is our mission at risk?"

Gathering the pieces

As we hold these questions and gaze upon the broken institutions in our care, we may find ourselves standing shoulder to shoulder with Jesus. In a provocative image that complements the pieta-like image of Paul, Matthew's Jesus compares himself to a mother hen who longs to gather up her children, as he looks upon his beloved, broken Jerusalem, an institution that "kills its prophets" and knows not its own power (Matthew 23:37). As we look upon the scattered, broken fragments of our institutions, we too may feel like the mother hen who longs to gather it all up in one big loving embrace.

At times NACC chaplains struggle mightily to continue to love institutions that forget their own power. It is exhausting to hold and love anything that forgets who it is and acts, as institutions sometimes do, in self-destructive ways. A chaplain may wonder, am I strong enough? Do I have enough memory, enough courage, enough love to keep reminding this broken institution of its beauty and true power, and the bigger story of which it is a part?

It's a lot to hold, even for a strong chaplain. But we need not hold all this alone. We have strong, loving, like-minded colleagues, brothers and sisters within NACC and beyond, with whom we can share the load, who remind us of who we are and what we are capable of, even when we start to forget. Most of all, we have our God who tenderly holds all of us, our institutions included, in a loving embrace much bigger than we can imagine.

References

¹ C.f. Bechtle, Regina, S.C, "Giving the Spirit a Home: Reflections on the Spirituality of Institutions," From Z. Fox and R Bechtel, eds, *Called and Chosen: Toward a Spirituality of Lay Leaders* [Lanham, MD: Rowman and Littlefield, 2005], p. 100. ² *Life of Paul*, Aidan Hart in collaboration with Donald Jackson, Copyright 2002, *The Saint John's Bible*, Saint John's University, Collegeville, Minnesota, USA. ³ See Exodus 12:14, Deuteronomy 8:2, Psalm 103:2, Luke 22:20, John 14:26, 1 Corinthians 11:24.

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Can chaplains reduce a hospital's readmission rate?

By Roberta Holley, Rabbi David Keehn, and Jess Geevarghese

Myth: Chaplains are nice to have in hospitals but not essential. Chaplains are a luxury, not a necessity.

Fact: We live in a healthcare environment that's driven to deliver higher quality care while lowering costs. Without the data and evidence that chaplains contribute significantly to these goals, some hospitals might be unwilling to have paid chaplains on staff, and fewer people would get the expert help that chaplains provide.

The Need: Chaplains can develop and manage pilot programs to begin building the case that chaplains contribute significantly to higher quality care and an improved patient experience – both of which contribute to an organization's bottom line and reputation.

The American healthcare system exists in a state of flux. The Affordable Care Act has put increasing pressure on hospital administrators to provide high-quality care more efficiently. What can we do to assist our administrators? While keeping to our core mission of providing spiritual care, we can strengthen chaplaincy's contribution to the overall goals of the hospital.

Hospital administrators are concerned about hospital readmissions and patient experience. The ACA in 2012 authorized the Federal Centers for Medicare and Medicaid Services to penalize higher-than-expected 30-day readmission rates for heart failure, heart attacks, and pneumonia by decreasing those hospitals' Medicare payment rate across all discharges.

Numerous studies have indicated that hospital readmissions are a significant problem, both for patients and the healthcare system in general. At the national level, among older Medicare beneficiaries, 20% of hospitalized patients are readmitted within 30 days and 56% are readmitted within a year. A 2009 study estimated the cost of these unplanned rehospitalizations at \$17.4 billion a year. Many of those readmissions are due to unanticipated change in a patient's condition or a planned follow-up treatment. But some result from patient confusion over new drug regimens, inadequate follow-up with primary care physicians, anxiety, and isolation.

"Can Chaplains Lend Their Talents to Readmission Reduction?"

HealthCare Chaplaincy Network asked the question, "Can chaplains lend their talents to readmission reduction?" With a grant from the New York Community Trust, we partnered with New York Hospital Queens to seek an answer. Initially, the project focused specifically on patients suffering from heart failure, heart attacks and pneumonia, as studies have shown that these are the three populations with the highest likelihood of readmission to hospitals within 30 days of discharge (and the three groups that the Centers for Medicaid/Medicare Services tracks). Then, as the pilot continued, we expanded the patient population to Medicare fee-for-service patients with a high risk for readmit status.

Every discipline has a role to play, and concurrently, NYHQ had a social work intervention for the same population. We worked closely with the hospital team to ensure smooth communication between the two groups. Ultimately, the patients we saw were older adults who had been readmitted after the social work intervention, or those who refused the social work intervention and who were not seen by social work due to distance, but were considered high-risk patients with any diagnosis.

What Did the Pilot Involve?

Roberta Holley, an experienced hospital chaplain, visited patients over a six-month time frame in the hospital to conduct a chaplaincy visit. Then, she would describe the program and ask if the patient would participate. If the patient consented, Chaplain Holley visited the patient while in the hospital, once or more depending on length of stay. Once he or she was discharged, Chaplain Holley would call twice in the first week and once a week for the next three weeks to follow up on their transition home, conduct a chaplaincy visit over the phone to address any spiritual/emotional concerns, and ask specific questions regarding care. If the patient expressed any medical concerns or questions, Chaplain Holley would connect the nurse case manager to the patient.

What We Learned To Date

While the project was aimed at patients, caregivers need just as much care, if not more than the patients. Caregivers were anxious, needed someone to hear them out, and often had no one to talk to about the situation. The importance of chaplaincy support of the family caregiver seemed a critical finding that has not yet been reported in a science of chaplaincy paper.

Most patients welcomed the spiritual, emotional and practical support given in the hospital and post-discharge. Men were less likely to get into deep meaningful conversations. The practical support included Chaplain Holley working as a liaison to care management and being a sounding board about difficulties procuring prescriptions, medical equipment, need for palliative care, and advance directives. Chaplain Holley could see the effect of chaplaincy with angry patients or caregivers, whose feelings would ease with

dialogue. While this was a chaplaincy intervention, Chaplain Holley was part of an excellent interdisciplinary team comprising chaplaincy, care management and patient experience departments.

Chaplain Holley has worked with 158 patients, of whom 16 were discharged to a facility, five died and one refused the program after consent. The program is still under way. To date, 20 patients were readmitted, which is slightly lower than NYHQ's average readmission rate for the core measures. While the results are preliminary, we don't expect to be able to draw definitive conclusions of the effect on readmissions. However, we anticipate the insight of the qualitative findings has created a new space in the existing literature. Our findings have set the foundation for designing empirical studies in this realm of chaplaincy research and quality improvement programs nationally. We will report on results when final.

Chaplain Holley says, "As the chaplain, I realize that it is a privilege to take the time to hear the patient or caregiver out, to discuss the issues and concerns that are affecting quality of care and recovery, and to have the ability to take action of their behalf. This action may range from praying to interceding with the the multidisciplinary team that affects the patient's care."

Roberta Holley is the chaplain dedicated to the New York Hospital Queens' readmissions reduction project. Rabbi David Keehn is director of pastoral care at New York Hospital Queens. Jess Geevarghese is senior director of business development and initiatives at HealthCare Chaplaincy Network.

The value of chaplaincy? Priceless

By Blair Holtey

There was this fellow who was not too happy with life. He was the kind of person who, if told to have a nice day, would respond with something like, "That's okay, I already made plans." He reminded me of a blowfly, and his words were like the larva that finds its place on open wounds and sores and causes disease. I'm sure you've met him before. I will call him Mr. Green.

I was in my 20s when I met Mr. Green. He lived in the nursing home I sang at each week. I was known as the strolling minstrel, and I would knock on as many doors as possible, ask if the resident wanted to hear guitar music, and provide bedside melodies. For over a year, I would knock on this man's door, say "Hello" and ask if he wanted a visit. The reply was always the same: "@#\$%," and he'd always tell me where I could go! Every week it was the same kind of response, but I never stopped.

After a while, I wondered what would happen if I didn't knock, if I didn't ask to enter; rather, I would just walk slowly by so he could see me and hear me outside the door, but I wouldn't pay attention to the man. That is exactly what I did for a couple weeks, until one day Mr. Green yelled out from his room, "Hey there!" He called me by my last name (I didn't know he knew it). "You don't just go walking by my room without stopping to say 'Hello.' Aren't you going to ask me if I want to hear your @#\$% music?" I responded that I didn't think he cared. He told me I didn't have a right to ignore him. From that day forward, I was invited back into his room, and we eventually got to know one another. I can't say we became friends, but I can tell you that he was befriended. I continued to stop by his room every week but never played my guitar or sang; just sat at his bedside listening and indulging in reminiscence.

This experience with Mr. Green taught me, at an early age, that the gift of presence cannot be valued or undervalued, whatever way you want to put it. Similar to the Mona Lisa, it is priceless. How can we put a price on human presence? What value did Mr. Green's "actual being" play in the life of a young man? We don't know. We can't place a value on his life or on the lesson I learned that day.

On an occasion where we love as Jesus loves us, we find openness to the transcendent. Mr. Green's openness to a strange young man, pounding "Kum Ba Yah" on his 12-string, was probably just short of a metanoia moment! I believe that our cultural boundaries were lifted, and we both experienced meaning in life and how to live morally.

Chaplaincy is an encounter when God invites us to provide an atmosphere, no holds barred. The phrase "no holds barred" refers to the way people used to wrestle before rules were designed to keep the athletes safe. Literally, one could wrestle with any move, regardless of how much it might injure the other contestant.

The value of chaplaincy is just that: there are no rules, except to value each encounter with another person. We hope that one's clinical pastoral education has taught the minister to use various modalities to reach those he/she encounters.

And what have others said about the value of chaplaincy? The answers vary.

I have sung with teenagers at the bedside when they see the response of a dying cancer patient, and their face lights up! Value? Doctors gave me varied responses. Some stated they were not sure about our value, while others have told me we play a vital role in the care of their patients. Very recently, a local businessman called to let me know how much chaplains mean to him, that they are the most important people in the hospital because they bring people to the Divine Physician and provide openness to being healed by the medical staff. Articles report the monetary value of chaplains.

But the value of chaplaincy is ineffable. There are endless opportunities to invite people to the table of Jesus, and to illustrate the correlation between human experience and the Gospel of Jesus Christ. But to "do" theology, to describe the value of our work, it needs to occur where one person encounters another in all rare forms.

Blair Holtey, BCC, is pastoral care coordinator at Mease Countryside Hospital in Safety Harbor, FL.

What is the value of CPE to an institution?

In addition to providing training for future chaplains, a CPE program offers many benefits to the institution that hosts it as well. Marika H. Hull, a member of the NACC Editorial Advisory Panel, recently asked Sr. Claudia Blanchette, SNDdeN, about the ways that clinical pastoral education can add value to a hospital and the larger community.

Sr. Claudia is Director of Clinical Pastoral Education and Spiritual Care at Holy Family Hospital, a 254-bed community hospital, in Methuen, MA, which is part of the Steward Family Hospital System. As a Sister of Notre Dame de Namur, she views her ministry of CPE supervision as participation in the healing ministry of Jesus to persons of diverse faith traditions, life circumstances and cultures.

Sr. Claudia served as the founder and head of the former graduate ministry program at Emmanuel College in Boston for 30 years. She completed four units of CPE during a sabbatical year and decided to enter CPE supervisory education. She has served as an ACPE supervisor since 2001 in the former Urban Parish CPE program at Emmanuel College, at Beth Israel Deaconess Medical Center in Boston, and now at Holy Family Hospital in Methuen, MA. She holds a BA from Emmanuel College, an MA from Boston College, a diploma in pastoral theology/ministry from the University of Strasbourg, France, and a PhD in religious education from Boston University

Marika Hull is a full-time chaplain at Saint Anne's Hospital in Fall River, MA. She is a CPE supervisory candidate under the direction of Sr. Claudia Blanchette.

How does CPE fit with the mission of the hospital?

Holy Family Hospital is a community hospital, and CPE is valued for outreach to patients, families and staff, as well as for service to the community. The mission of the hospital within the Steward system focuses on outreach to the community, and the CPE program mirrors this focus. Chaplain interns go out of the hospital to other sites in the community to do clinical work and to attend community programs. The hospital administration stresses outreach to the community and values CPE for its participation in this outreach.

How is the CPE program received in your hospital?

The CPE program at HFH was established way back in 1975 under the Sisters of Bon Secours. The current hospital president, operating officers, and the other department heads see CPE as an integral part of the culture of the institution, and they value the contribution CPE makes to the hospital community and to the surrounding communities.

What is the value of CPE to the hospital? What are some of the challenges?

Our biggest impact is in what we do for the patients, staff, and the community. A big challenge is how to implement new and creative programs. It helps that we are a faith-based hospital. A non-faith-based setting would present different challenges.

Departmental agendas are already so full, why add CPE to the mix?

Overall, a CPE program enhances the possibilities of care for patients, families, and staff. It adds additional opportunities for spiritual care and opportunities for diversity. Also, it offers more outreach to the community.

There are many benefits to the CPE program. We are able to provide more people to reach out to patients and to do creative things. For example, spirituality groups on our behavioral unit that are led by chaplain interns are now part of ongoing modalities that we offer to patients. Chaplain interns bring in their creativity and new ideas. As for long-term benefits, patients experience greater satisfaction as we provide ongoing attention to their emotional and spiritual strengths and needs.

Also, the chaplain interns function as part of the spiritual care team as they interface and collaborate with the Catholic priest chaplain on staff. In clinical areas where there are regular rounds, the chaplain interns attend and are well received and relied on by the staff.

What kind of coverage do you have in your department with both chaplains and chaplain interns in the CPE program?

Our department includes myself and a priest chaplain. We also have volunteers who serve as Eucharistic ministers. Protestant and Latino chaplains also serve our patients part-time and are provided by an outside organization called Communities Together. Except for two to three weeks between each CPE unit, we also have six to ten chaplain interns visiting patients throughout the week.

On a daily basis, the Catholic priest chaplain is available four days a week, Monday through Thursday, for sacramental coverage

and emergencies. Chaplain interns do their clinical time throughout the week. We also call on local parishes for sacramental coverage as needed.

What are some of the difficult aspects your double duties as director of spiritual care and CPE supervisor?

I do have to wear two hats. What I find challenging is the need to multitask, and certain times of the year are very intense. I have administrative responsibilities to attend to as director of a department as well as my CPE program components, and national and regional ACPE duties. For example, I find that each December many things need to be done before the end of the year, and it is challenging to handle the many tasks that need attention at that time. But that's true of many administrative jobs. It helps that spiritual care and CPE are integrated in their service to the hospital, and what helps the most is that the hospital appreciates and values CPE and spiritual care.

What keeps you motivated to continue with CPE in your mix of spiritual care services?

What's most rewarding for me is to be working with people for their growth and learning, and empowering them as they seek to become chaplains and pastors. I am grateful for the opportunity to journey with people to help them develop the skills necessary to provide spiritual care in a hospital setting to people of many different faiths and cultural backgrounds. Each chaplain intern is unique, and I enjoy their uniqueness and their creativity. They are trying to be the best person and chaplain they can be, and I get to accompany and empower them in this effort.

I am also very grateful through CPE to be part of the bigger picture of the mission of the hospital. With our chaplain interns, we who are involved in spiritual care are better able to serve the needs of the hospital, and in turn better able to help the hospital achieve its mission of providing good care for the community.

Categorizing CEUs for Renewal of Certification

By Mary Davis, NACC Certification Commission

Recording your continuing education since your certification or last renewal period is an opportunity to demonstrate how you continue to meet the current NACC Standards and competencies.

Whether you record your hours as they happen or work from a stuffed file when your five-year mark comes near, your best bet is to keep the NACC Certification Standards on hand to categorize your coursework. Keeping the Standards' sections in mind and referring to them regularly will assist your integration of them into your professional practice as well.

Recording your hours as they occur or planning the type of education you will seek in a given year is the optimal way to be intentional about your learning and ensure a balance in your activities. You can easily see by midyear if you already have an overabundance of education related to pastoral competence, for example, and note that you need more specific education related to theory of pastoral care. You can then seek out suitable presentations, webinars, readings, DVDS, or workshops on related competencies.

When the Certification Commission reviews renewal packets, we notice that many chaplains struggle with where to record certain educational activities, and some continue to include activities that are not reflective of the Standards. For instance, most people put any type of retreat under the Identity and Conduct section. However, the retreat may have focused on spiritual dimensions of human development (302.3) or highlighted one of the Catholic social teachings (302.21). In that case, the Theory of Pastoral Care section might be more appropriate. Some persons include attending Mass, going to symphonies, or doing nature walks. While these activities are no doubt conducive to well being, they are not likely to fit the important question of "Was it of an educational value to your ministry?"

The section that seems most challenging for persons seeking renewal is Identity and Conduct (NACC 303-303.9). Educational experience related to professional ethics, pastoral identity or pastoral authority, self-reflection, wellness, advocacy, pastoral qualities (enhancing your strengths as a minister), and personal spirituality experiences would fit well here. Retreats and spiritual direction are only one dimension of what can be included in the Identity and Conduct section; be creative in seeking educational experiences in the next few years that will expand how you demonstrate these competencies!

Discussing the meaning and effectiveness of your continuing education hours is one aspect of your five-year peer review. You can discuss how to gain more balance, and ideas about new opportunities can become a recommendation for the future. You can also set your own goals for working on educational opportunities for a specific section that has not been easy to obtain in the past, or competencies that have been added since your original certification.

Many educational experiences are available through webinars, audioconferences, and educational presentations offered by professional chaplaincy organizations and major healthcare systems – particularly if local availability of workshops is limited and travel is challenging. No matter how you obtain your required continuing educational hours, be intentional about tying them to the recommendations received in your last interview or peer review session, and to the current NACC Standards. Your integrity and professionalism will be greatly enhanced, benefitting not only yourself but the people of God whom you serve as well.

See also:

- Certification Procedures Manual, Part Two, CP21-232.9 (for specifics related to documenting continuing education hours)
- NACC Standards for Ethics, Certification and Renewal of Certification, Standards 306-306.5 (for standards correlating to the Continuing Education Hours Form)
- [Frequently asked questions](#) about NACC Certification and Renewal of Certification: (scroll down to "About Renewal of Certification" section)

Conference outlines research agenda for spiritual care

By Mary Heintzkill

In April, I had the privilege of attending the HealthCare Chaplaincy Network's first annual conference, titled "Caring for the Human Spirit: Driving the Research Agenda for Spiritual Care in Health Care." The conference presented both a challenge and a charge for chaplains to explore their discipline using research to tell the chaplain's story better. From start to finish, I was deeply engaged; I was fascinated by the current research, intrigued by the new questions this research is raising, and enthused by how research in spiritual care will and already does affect the patient experience.

Current research is addressing many questions related to the chaplain's role and contributions. A primary question that needs further exploration is: "What exactly does the chaplain do?" As our discipline evolves, we need more evidence-based practice. For the sake of the patient, it is no longer acceptable for a chaplain to show up and leave saying that something significant was done, while not being able to articulate what we did and why our presence was vital to the patient's well-being. Patient-centered care demands that chaplains be able to articulate the unique contributions they make.

As new questions about the chaplain's role arise, it is important to frame our work in a clinical context of assessment, diagnosis, intervention, and outcome. The chaplain must be able to **assess** the current spiritual state of the patient. Is the patient experiencing spiritual distress? If so, what is the **diagnosis**? In other words, what issue does the chaplain specifically need to address? Having determined that, the chaplain needs to **intervene** in order to better align the goals of the patient with the goals of the care team. Finally, what **outcome** was achieved, and how do the chaplain and the care team know? What is different for the patient because the chaplain provided an assessment, diagnosis, and intervention? How did the chaplain specifically contribute to the patient's well-being?

In this context, the interdisciplinary team will be able to understand the chaplain's role and work. The team will also be able to understand the invaluable contribution that chaplaincy makes to improve the care of the patient. Additionally, providing spiritual care within this framework will ensure the highest quality of care for the patients in the organizations where chaplains serve.

By utilizing this approach, chaplain research will be able to explore questions that will lead to greater clarification about what it is that chaplains do, why they do it, and what difference it makes. If we can do that, we can tell the story of how we contribute to greater quality of life for patients, family, and staff, and we can improve the care of the human spirit when the devastation occurs.

Mary Heintzkill, BCC, is director of spiritual care at Borgess Health in Kalamazoo, MI.

Beyond theodicy: Let emotional support shape reaction to suffering

by Vic Machiano

Margaret Mohrmann claims that theodicy is "the theological enterprise of justifying God in the face of evil." But this traditional understanding is not useful in the practice of medicine and chaplaincy as played out in clinical encounters. The term can be viewed in three dimensions: intellectual, personal, and emotional.

The intellectual view addresses the reality of suffering by attempting to reason the nature of the God in whom we believe. The construct of such an investigation is a series of statements that, taken individually, offer nothing objectionable. These statements include: God is entirely good, God is all-powerful, and suffering exists in the world. This intellectual exercise is proper to the classroom, but not in the clinical encounter.

The personal view is where most encounters with theodicy take place on the part of the sufferers and those who care for them: "Why does God allow this suffering/situation to happen to me/my family/my friend?" It directly reflects the experience of the person who suffers or for whom we care. As a hospital chaplain who is present when bad news is delivered, I have seen the hope that they have placed in God and medicine suddenly taken away from them. In that moment before reasoning, very personal feelings are shouted out. The very first response is one of denial. What one hears most often are statements like "NO!" "This can't be happening now. He was just about to get married," and "This is not supposed to happen; she was just here to have her gall bladder taken out." This is an initial, unthinking, striking out that can best be responded to by reverent silence. There will be a time for verbal response, and it must come as part of a best practices clinical setting, because "many physicians and, I suspect, many chaplains know that questions so difficult to formulate and so frightening to broach, similar to ones about the imminence of death, once deflected are in many cases never attempted again." (Mohrmann 64)

Wendy Farley writes, "We all know we will die, but when we are faced with our own death or the death of a child or other loved one, that knowledge is transformed from general, abstract information into the unmaking of the world" (106). This transformation always moves from the universal to the particular. The reasons behind particular views are the beliefs or traditions of those who hold them. Given that, is there any wonder why such reasons are so varied? As a chaplain I can attest to the case(s) in which the justification is not about God as much as it is the seeking of the causation of the suffering. What brought this to me? Why is this happening now? Why did my son get this disease?

Rather than theorize about how God is both good and all-powerful at the same time, the sufferer seeks to find answers that validate and restore his image of God. He will attempt to craft a solution that can eliminate any role that God played in his current suffering. This is most often reflected in a narrative that describes previous acts as deserving of the current state of suffering. I have witnessed times when, upon learning that a loved one is dead and after the initial outburst of denial, a mourner will state over and over, "God is good." It takes on the quality of a mantra. It is as if the mourner is somehow attempting to avoid the situation where "one is left with only two deeply destructive alternatives: to embrace a troubling image of God or reject God altogether." (Farley 110)

At moments of bereavement, I have seen loved ones thank the doctors for all that they have done. This appreciation crystallizes, for the doctors and the sufferers, that "all that they have done" is all that they could do. The time of explanation is over. We know what caused the pain, suffering, and death, but we are still at a loss to understand why. This is not the role of the medical professional. It is here that the chaplain's skills of listening and helping the sufferer to develop new coping mechanisms are most useful. The suffering has to be sensible. It provides a space for the loved one's family to create and impart some meaning to the suffering. These relationships are created not so much through the bond of shared suffering (for the chaplain has not directly suffered), but through the bond created when people approach mystery together.

When this relationship is beginning to be expressed and the mystery of our finitude approached, it is always incorrect to provide dismissive answers to the question of why. Answers such as 'why not' or 'that's life' or 'it's God's will' do absolutely nothing to build the relationship needed by the sufferer or the loved ones. Our compassionate response to the sufferer transcends any power that suffering and death have.

While the emotional view of theodicy can be viewed as an extension of the personal view, it also contains a request for understanding that is an important aspect for the sufferer. The emotional view is most often expressed in either silence or the single word, "Why?" The construct that is most compatible is to be found in the Book of Lamentations and the Psalms. Lamentations is a short book of the Bible that bemoans the captivity of Israel and loss of Jerusalem. Importantly, it only seeks solace in one verse of the entire book, "Lead us back to you, O Lord, that we may be restored: give us anew such days as we had of old." (Lamentations 5:21 NAB)

The class of prayer known as a lament contains six elements: an address to God, the complaint detailing the suffering at hand, an expression of trust in God, a petition to God for intervention and deliverance, a statement of the petitioner's confidence that the prayer will be heard, and the offering of a vow of praise to God before the community. The Psalms that can be categorized as laments are divided into laments of the community or the individual. They are numerous (some fifty-nine Psalms have some lament in them). The emotional response, along with the personal, covers the experience of suffering and pain in a way that the intellectual cannot.

Theodicy in the clinical setting ought not to attempt to explain suffering by logically trying to find a god who is both all good and all powerful. A god whose will is bent on the destruction of a person's dignity is one in whose image we have not been created.

One night, I was sitting with a woman keeping vigil over her son who had entered the dying process. After a while, she turned to me and said, "Pastor, he's on a cliff and he sees the light on a mountain far away. I hope that he has accepted Jesus because God is good." I looked into her eyes – now moist with tears – and said to her, "God *is* good, and so I know that Jesus has accepted him. And when your son takes a step off that cliff towards the mountain, one of two things is going to happen: either he will find firm footing or he will learn how to fly." She smiled.

Vic Machiano, BCC, is night chaplain at Parkland Hospital in Dallas, TX.

For further reading

Anderson, Bernhard W. *Out of the Depths: The Psalms Speak for Us Today*. Philadelphia: The Westminster Press, 1983.

Murphy, Roland E. *The Psalms, Job (Proclamation Commentaries)*. Augsburg Fortress Press, 1985.

Mohrmann, Margaret E., and Hanson, Mark J., eds. *Pain Seeking Understanding: Suffering, Medicine, and Faith*. Cleveland: The Pilgrim Press, 1999.

Farley, Wendy. "The Practice of Theodicy." Mohrmann and Hanson 103-114

Mohrmann, Margaret E. "Someone is Always Playing Job." Mohrmann and Hanson 62-79

Sulmasy, Daniel P. "Finitude, Freedom, and Suffering." Mohrmann and Hanson 83-102

Book review: Lives of the very poor offer insight into blessings

Reviewed by John Gillman

L. Susan Slavin and Coralís Salvador, *What's So Blessed About Being Poor? Seeking the Gospel in the Slums of Kenya*. Maryknoll, NY: Orbis Books, 2013, 161 pages, \$23.

In the epilogue to this book the co-authors identify their experience of the call of the divine: "If you are lucky enough to find a place that touches your soul, then you go" (p. 158).

Originally from the Philippines, having worked as an administrator of an investment banking firm, and having raised five children, Coralís Salvador left behind her way of life in San Francisco to become a lay missionary in Kenya in 2001, where she has served for over ten years. Susan Slavin, an attorney in the area of family law and women's rights, became a Franciscan lay missionary and joined Coralís to work among the poor in that country as well.

Wanting to understand how the very poor could be called blessed, Susan searched public libraries of Long Island and found no answers. Coralís challenged her to "put down her books and come and see," an invitation that echoes the apostle Philip's invitation to Nathaniel in John 1:46. In this engaging, often disturbing narrative the co-authors tell the stories of the poor, orphans and women, whom they have served.

We hear firsthand from those diagnosed with HIV/AIDS what "blessed are the poor" means to them. For 23-year-old Joseph with a history of drug addiction and now working as a community leader, it means "every single moment passing is like a miracle." One moment you are hungry, and the next you get some twenty shillings (about thirty cents). For Tabitha, whose father died and mother is HIV positive, "blessed are the poor" means you have faith in your heart and you do not take yourself to be very righteous (p. 141).

Not all has gone smoothly for Coralís. In 2009 she was fired as human resource director of Maryknoll Lay Missioners, partly for being, she surmises, too intimidating in confronting those who mismanaged funds in a well-drilling project. Though feeling bereft and betrayed, she continued her work at the orphanage she founded for those with AIDS/HIV.

The authors find inspiration in liberation theology's emphasis on God's preferential option for the poor, a development which has been viewed with skepticism by some church leaders. The recent meeting of Pope Francis with Gustavo Gutiérrez could mark a thaw in the tension between the Vatican and liberation theology.

Two other relevant books are *On the Side of the Poor: Liberation Theology, Theology of the Church*, co-authored by Gutiérrez and Archbishop Gerhard Müller, the current head of the Vatican's doctrinal congregation; and *In the Company of the Poor*, co-authored by Gutiérrez and Paul Farmer, a physician who co-founded Partners in Health and served as a plenary speaker at the NACC national meeting in Corpus Christi some years ago.

Inviting us into close conversations with those who manage with very few material resources, afflicted with loss and illness, yet not without hope, the authors bring us face to face with the lived experience of the first beatitude, blessed are the poor. I doubt that many will be untouched.

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Book review: Migration through the lens of the Bible

Reviewed by John Gillman

Deirdre Cornell, *Jesus Was a Migrant*. Maryknoll, NY: Orbis Books, 2014. Pp. 133. Softcover, \$20.00.

While the national debate on immigration policy in the United States continues to heat up, the probability for meaningful reform seems to diminish as the midterm election draws closer. The U.S. Catholic bishops have reiterated the stance they took, together with Mexican bishops, in the document *Strangers No Longer: Together on the Journey of Hope* (2003), namely, that persons have the right to immigrate and that nations have the right to secure their borders. The rub comes in balancing these two, often competing rights. Poignantly highlighting the plight of immigrants, the bishops on April 1, 2014, celebrated mass at the border in Nogales, AZ, distributing communion through slats in the steel fence that painfully divided the body of Christ.

Deirdre Cornell provides a valuable resource for reflecting theologically on the migrant experience. She supports the title to her book by framing Jesus' journeys in the context of being a migrant. Jesus' travels, some forced, others voluntary, are prompted by various circumstances: a mandated census (Bethlehem), life-threatening circumstances (escape to Egypt, and later, escape from Nazareth), and religious expectations (Jerusalem). She also names metaphorically the incarnation, Jesus' "journey" from the heavenly sphere to life on earth, as a migrant-type experience.

Throughout her narrative, Cornell weaves in stories spanning over 20 years of her experiences living among and advocating for migrants, largely in upstate New York. She relates moving vignettes of visiting those imprisoned, serving as a catechist, and facilitating Posadas. Like her grandparents, who started the Catholic Worker house in Cleveland, Cornell not only embraces but also lives out Catholic social teaching by standing with the homeless and displaced, the poor and the marginalized.

Not limiting herself to Jesus alone, Cornell considers how several other Biblical characters have been displaced, deported, or disenfranchised. These include Adam and Eve, Abraham, Joseph (the son of Jacob), the Magi, and Jesus' parents, Joseph and Mary. She invokes the forty years of wandering in the desert, the exile of the Jewish people, and the status of early Christians as "aliens and exiles" (1 Peter 1:11) as paradigmatic events for interpreting theologically what contemporary migrants experience.

In only mentioning Hagar in passing, Cornell missed an opportunity to name how she, as an outsider, was abused and forced into homelessness (Genesis 16). It is well known that many single women from minority cultures can identify with her experience.

Cornell's reflections can serve as a launching point for spiritual care departments and parish pastoral teams to reflect on how their respective communities provide hospitality for and address the needs of migrants in their midst. Is a prophetic voice to be exercised on their behalf?

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