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THE NATIONAL ASSOCIATION OF CATHOLIC CHAPLAINS

CONTENTS

Letter: Telling doctors to leave isn't productive

Editor:
Thank you for the article, "Spiritual care is medicine's missing element" describing Rev. Dr. Sulmasy's view of integrating spiritual care.

I would like to address the comment that was made that if a chaplain is visiting a patient, the doctor should come back later. Whew, we need to make some distinctions. Maybe under certain circumstances, this could be the case. However, despite the chaplains' applause, let's be real. People are in the hospital for medical treatment, not spiritual solace and problems; doctors are on tight schedules; chaplains are not.

We as chaplains might feel important, and are, but telling a doctor to come back is not only bold, it is rude. I recall on occasion a physician volunteering to come back later, and rarely was this acceptance warranted; usually a minute or two was all that was necessary to finish up the visit, and this can be simply stated to the doctor. Let's not get inflated egos over these power struggles. Rev. Dr. Sulmasy misspoke in his enthusiasm to support pastoral care of the sick. We don't need chaplains confronting and turning off doctors if we expect their cooperation. We need to distinguish acute care situations from hospice in this discussion and also include the conversations that take place with family members.

Sincerely,
John P. Stangle, NACC Chaplain Advanced Emeritus

Executive Director's Reflection: As chaplains, let's find existing needs to meet

This issue of *Vision* explores how pastoral care departments are stretching resources and taking steps to extend their reach. David Lewellen, our editor, invited contributions by asking, "As staffing levels shrink and patient loads increase, what is a chaplain to do?" This topic surfaced because so many of you have faced, are facing, or will face this challenge. Staffing is a critical issue.

Back in my consulting days, I was taught early that we could not be operation- or service-driven, but market-driven. An operation- or service-driven consultant firm would try to sell potential clients on the services it knew, and try to convince them they needed the services. But as a market-driven firm, we spent time learning what the potential clients needed, then designed our services to meet their needs. It was actually a much more creative and life-giving approach. We could not rely on templates of past services for proposals, but needed to tailor each one based on what we learned. The first part of our proposal always listed what we heard, the issues identified, the assumptions behind what we proposed, and then how we would design services to meet those needs. That proposal induced dialogue between us and the potential client. In the end they owned the service as well, as it reflected their reality, not a service we provided elsewhere.

I think back on that as we grapple with our spiritual care services and how we want to make the case of staffing in our current service environments. Do we just try to offer what we do the way we did then, or do we hear new needs and/or services asked for?

Over the past two-plus years, the Staffing Subcommittee of the CHA Pastoral Care Advisory Committee has struggled with the staffing question as well. Members of the committee are mission leaders in Catholic healthcare who are responsible for pastoral care within their systems. A couple of years ago, we dreamed of a TurboTax-type software that would allow all of us to plug in key data and get the exact right number of FTEs for a given institution. But that idea faded as we realized the complexity of the staffing issue.

The Staffing Subcommittee did an excellent job in preparing an article for the most recent issue of *Health Progress* (September-October, 2014) titled "Spiritual Care in the Midst of Health Care Reform." It is a meaty article that highlights the multiple factors in spiritual care staffing. It provides no simple formula but offers concrete next steps for any system/hospital struggling with staffing. It reiterates the Ethical and Religious Directives' insistence that "A Catholic health organization should provide pastoral care to minister to the religious and spiritual needs of all those it serves."

As chaplains, we have provided service in a certain way – in acute care when beds were full. Now I find myself asking, How can we take a market-driven approach to our challenges today? How do we listen to our "potential clients" (in this case, our employers) to learn what they need from spiritual care and then design our services accordingly? Perhaps this article on staffing in Health Progress can be an opportunity for us to do some market listening.

I think we can be encouraged by the fact that the authors identified three core competencies for chaplains: spiritual assessment and care; education; and ritual ministry. The authors might be doing us a service in naming three, rather than reiterating our 13 standards of practice. Perhaps we can view these as a client needs assessment as well? Our services of spiritual assessment and care are needed in every setting. We are certainly familiar with ritual. But what about education? That is a service some of us might now do well, and others need to develop to meet their clients' (employers') needs. How do we not just sell what we have done before, but what we need to add? Let me quote from the article to help us envision what is needed (and being done everywhere):

> In hospital as well as non-acute settings, chaplains assist in the orientation and formation of new staff, physicians, residents and medical and nursing students. They present the holistic care model and discuss integration of spiritual care in the patient care plan. They also educate clinical care providers on how to conduct a spiritual screening interview. This includes how to identify spiritual distress, what conditions indicate the need for a referral to spiritual care and what a chaplain's formal spiritual care assessment and plan entail.
>
> Some chaplains have created educational materials to help staff meet religious/cultural expectations of patients and families. In providing ethics education to clinical staff, chaplains can work with them to help patients and loved ones with values clarification around medical ethics decisions and the completion of advanced directives.

So, my friends, do these paragraphs reflect an opportunity to strengthen our competency as educators, and design services to meet a need?

Along with reading the wonderful contributions of our members to this issue on creative staffing, I encourage you to read the above-cited article, as well as another article in that same *Health Progress* issue titled "CHA Chaplaincy Surveys Offer Key Insights."

Vision, September/October 2014
www.nacc.org/vision

Effective pastoral visitors transcend language to meet spiritual needs

by Denice Foose and Theodore H. Smith

Jeff (a pseudonym) is a Caucasian Roman Catholic layperson, who serves as a trained pastoral visitor in the Department of Spiritual Care at Baylor St. Luke's Medical Center in Houston. On his weekly visit to his assigned clinical unit, Jeff met Juan, a 65-year-old Hispanic patient from a small town in south Texas. Earlier that day, Juan received a potentially fatal cardiac diagnosis, requiring a heart transplant. With his family still in their hometown, Juan suddenly faced emotional and spiritual distress alone. Jeff entered Juan's room knowing only his name, age and religious affiliation. His effort to establish an empathic presence with Juan became more challenging when he realized that neither spoke the other's language well.

However, through his genuine investment in making a pastoral connection, Jeff learned the broad outline of Juan's medical condition. More importantly, he felt some of Juan's understandable fear and the religious overtones of Juan's self-presentation. Jeff realized the potential meaning of his visit and had the courage to tolerate his own anxiety. A decisive moment in their conversation came when Jeff offered to read – from a Spanish edition – selected prayers from *Pastoral Care of the Sick*. While Jeff felt embarrassed by his stumbling Spanish, Juan was nonetheless moved to tears, literally, by the transcendent assurance of God's faithful outreach of pure, unbounded love to all God's children. To complete this visit, Jeff made a referral to the staff chaplain assigned to that unit for her follow-up ministry.

Jeff drew upon his training as a pastoral visitor, especially in the art of empathic listening, along with the traditional resources of ritualistic prayers of the Catholic faith. The combination enabled him to conduct a truly effective initial visit to a lonely, frightened man in a foreign setting. Moreover, Jeff's commitment to serve, while possessing a solid identity as lay caregiver, significantly enhanced the mission of the Spiritual Care Department.

This vignette illustrates how a lay ministry program can enhance a department of pastoral care. Such a program does not simply add to but improves the ministry of a department. Jeff's interaction with Juan was more than a greeting visit; it was an in-depth encounter, offered by a trained layperson giving expression to his life of Christian discipleship. This type of ministry creates a powerful middle ground, between the contributions of a sensitive volunteer and the professional expertise of a board-certified chaplain.

Of course, an effective lay program requires work. Administrative authorization, departmental support, educational opportunities, and personalized consultation are essential, and each has a distinctive function.

Administrative authorization at departmental and executive levels is a requisite first step, but it must be followed by meaningful support, especially at the departmental level. All members of the chaplains department, few or many, should be committed to the program's success, welcoming prospective members with genuine enthusiasm. Occasionally, ordained clergy feel threatened by gifted laypeople or underestimate their capacity to develop pastoral skills and acquire core knowledge. Neither response is healthy or professional. Finally, the title for the participant in the lay ministry program is vital. In our program, we avoid the word "volunteer" and use the title "pastoral visitors," to emphasize their distinctive identity as laypeople who have a heartfelt call to serve God and the Church in this capacity.

Another indispensable element is training. Over many years and working with scores of participants, we have found that laypeople want to be challenged in order to grow intellectually, relationally, emotionally and spiritually. The verbatim continues to be the single most effective teaching tool to equip people for pastoral care ministry – including laypeople. Difficult at first (as for all of us), writing verbatims generally become less onerous as laypeople increase their capacity to recall larger portions of the conversation. While never anxiety-free, these discussions help students grasp the fundamentals of pastoral presence, empathic listening, facilitating a person's expression, and tracking a person's story, plus limiting interrogatives and personal disclosure. An initial six-session, biweekly training program can provide a solid foundation to develop their ministry. Supplementing that introductory program with quarterly continuing education forums will keep them challenged and on a growth trajectory.

Personal attention also is integral. Hearing their name as they enter the department, receiving a personalized folder containing their patient list, reading a few instructional comments from their assigned staff chaplain, and finding a note of personal greeting in the folder are all powerful messages to the lay minister. They say, "You are important to us, and your ministry is vital to the mission of the hospital and department." Occasionally, the lay minister will require something extra – a time of personal consultation. Meeting that need lets them express their thoughts and feelings about an emotionally and spiritually demanding encounter.

"I'm a better spouse, friend, and caregiver because of the training through our Pastor Visitor program. I listen better and am better able to connect." This was Helen's comment in the concluding session of the program's five-part, three-month introductory training series. It reflects the breadth of the program's impact; it is a form of spiritual renewal for Helen as she continues to invest in ministry as a pastoral visitor.

Jeff and Helen's experience, or something like it, can be replicated with a commitment to an elevated vision of lay ministry. Concurrent with that effort, professional chaplaincy also is strengthened.

Denice Foose, BCC, is director of mission integration for acute care and the Rev. Dr. Theodore Smith is director of clinical pastoral education at CHI St. Luke's Health at Baylor St. Luke's Medical Center in Houston, TX.

Thinking outside the hospital for models of pastoral care

by Charles Stump

A generation ago, parish priests could provide much of the pastoral care needed for Catholics who were sick or dying. But changes in the church, and the healthcare system, have forced all of us to look for new ways of carrying out ministry. In the Diocese of Dallas, we have developed three models to meet our new and changing needs.

More than a decade ago, then-Bishop Charles V. Grahmann recognized, "Today health care places greater focus on the healing of the whole person. This has resulted in greater appreciation of a team approach to health care, and that team approach often includes the pastoral care of the patient."

The medical staff is focusing on cure, while the pastoral role of the chaplain is healing. Cure implies that we want to restore this person to who he or she were physically before the illness or injury, while healing implies that we want to continue the mission of Jesus by restoring the relationship between this person and God the Father. With many of our parishes consisting of 3,000 to 4,000 families and being served by one priest, that priest cannot also provide pastoral care to an 800-bed hospital within his territorial boundary. We needed a new diocesan plan to provide for the pastoral care of Catholics within the community hospital system. It was also important to honor the boundaries of pastoral care ministry and how it often overlaps into sacramental ministry and social ministry.

In the first model, the Diocese of Dallas employs three priests, two deacons and one religious sister to serve in five major hospitals (more than 300 beds) within Dallas County. As example, Parkland Hospital serves immigrants from many nations and the poor throughout Dallas County and records more than 18,000 births per year. The full-time Catholic priest assigned there provides for the sacramental and spiritual needs of the patients and their families, including daily Mass. The religious sister works closely with the pastoral care staff to provide pastoral care for Catholic patients and families, especially mothers going through difficult births.

In the second model, the territorial parish provides lay ministers who serve Catholics in the local community hospital and talk to the pastor about sacramental needs. An example of this model is a suburban parish with over 30 volunteers who have been trained and security-cleared by the hospital. The volunteers get a census listing of the Catholic patients from the pastoral care department and visit six days a week, providing spiritual support and Eucharist to the patients and families. Some parishes have also adopted the concept of lay ecclesial ministers of care, who coordinate parish volunteers not only in the local hospital but also assisted living, nursing homes and the homebound. In some parishes this work also extends to prison ministry.

In a third model, we have several Catholic lay chaplains who are employed by the community hospitals; this includes three Catholic CPE supervisors employed in three different hospitals. These chaplains are sought out by the local hospitals to serve their Catholic patient population, and many hospice organizations look for trained lay chaplains to support their mission of caring for the dying and their families.

As chaplains we are trying to keep our arms around the care for Catholic patients in the major hospitals today, but what about the future? Parkland Hospital will be moving into its new facility this fall and will have 862 single-patient rooms. UT Southwestern Hospital will also be moving this fall into a new facility with 460 beds. The average length of stay has shrunk, but that only increases the challenge to make at least one visit to the patient and family that says, "Yes, the Body of Christ cares that you are sick and suffering, and we join with you in that journey toward healing."

The Dallas Diocese contains six ACPE centers, and many volunteers have moved from the pew to completing at least an extended unit or even a resident program. Some chaplains have gone through the accreditation process with NACC or ACPE and are employed either part-time or full-time. Our hospital system is also growing outside Dallas County, into the suburban communities with parishes that exceed 4,000 families with two priests.

The question is, how are these parishes going to serve not only their own parishioners but also their visitors in the community hospitals? Also, is your hospital prepared to join with the local community for support in this team effort of healing? We need to continually think outside the box to care for our patients and families that are seeking spiritual healing.

Deacon Charles Stump is director of pastoral services for the Catholic Diocese of Dallas.

From Everlasting to Everlasting

"In the beginning, God created the heavens and the earth.
The earth was without form and void, and darkness was upon the face of the deep;
and the Spirit of God was moving over the face of the waters." (Genesis 1:1)

By Michele LeDoux Sakurai

In the beginning, change was in the air. We are a people of prophetic change – the parting of light from dark, rebirthing after the flood, newfound freedom after the parting of the Red Sea, the creation of a new vision through the life, death and resurrection of Jesus. All of our Christian history is rooted in change. We have been given no promises or guarantees, save the assurance that God will be with us in good times and bad.

Change is the calling of chaplains. We are invited into the joy of new birth, the fear of new diagnosis, the disappointments of failed interventions, the finality of death, and the promise of salvation. We are trained to be present, to witness the suffering, the surprise, the beauty, and the mystery of another's journey. Every journey is unique and often not predictable … so goes change.

With change oftentimes comes the darkness of the unknown and loss of control. In a culture that values and depends on control, change is seen as a threat. Living through the prophetic voice, chaplains have the opportunity to transform this threat into a reaffirmation of faith, translating the love of God through a language of hope and mystery. This is what chaplains do best.

But what happens when the crisis isn't simply about a patient or family? What happens when it is an organization, or healthcare in America, that is in crisis? This is not a philosophical issue somewhere out in the public arena. This change reverberates into the lives of chaplains and staff alike, and the angst of change has become a companion on the chaplain's journey. A distressed staff member, seeing the shift in healthcare, said to me, "This is not Catholic healthcare; this is not why I came to work in this hospital 20 years ago!" A nurse with many years of dedicated service shared with me, "I now simply put in my time and look to retirement." This spiritual distress on one level is no different from families who must accept the impending death of a loved one as an era in their lives. As with these deaths, chaplains are called to be a nonjudgmental presence in the death of processes and worlds that people have known and loved.

Yet the spiritual distress brought on by organizational change can be quite different for chaplains. It is much more difficult to honor the value of detachment when the change is personal. The change toward corporatization on the surface feels as if the Catholic mission is being pushed to the fringes. Staff see it, and chaplains feel this shift. Hospitals are restructuring and downsizing. Good and faithful servants – friends – no longer have a place at our sides. Our heads may understand the rationale, but our hearts do not. We feel a sense of injustice as we, too, mourn what we are losing. At times we may also question whether these changes reflect the essence of Catholic healthcare. To feel the grief during this time of change is to live into a pain both real and sincere.

We must embrace this desert experience if we are to be sojourners on this path. This is not a journey that we can control. We are here because we have been called into service, and we move forward believing that in the chaos, God remains part of the healthcare landscape. Our best skills will be put to the test as we mediate the challenges of change and the voice of hope and transformation. As chaplains, we are privileged to have a vision beyond the moment, beyond the fear. Change is God's invitation, "For I know the plans I have for you," declares the Lord, "plans to prosper you and not to harm you, plans to give you hope and a future." (Jeremiah 29:11) To be a messenger of such promise, what greater gift is ours to behold?

Michele LeDoux Sakurai, BCC, is manager of mission and pastoral care at Providence Health Care Stevens County in Colville, WA.

The balancing act of chaplaincy: Pastoral, personal, professional and financial

by Georgia Gojmerac-Leiner

As I reflect on shrinking pastoral care staffing, a couple of thoughts emerge. First, haven't chaplaincy staffing levels always been stretched over the patient loads and administrative duties? Second, in the final days of summer we might prefer to think about relaxing on the beach or taking a retreat rather than addressing the dilemmas of our work.

If it is true that we have always been stretched, what do we fear now? We may fear losing our jobs as well as for the patients' spiritual needs. A colleague of mine, an excellent manager, used to be in charge of a single rehabilitation facility. As the facility expanded to two, she became the director of two facilities. Now her facility has four campuses and she is responsible for all of them. Moreover, she reports that all department directors have been asked to cut their budgets by 3%-5%, resulting in staffing cuts. My colleague will obviously need to recruit volunteers, beyond the Eucharistic ministers and the on-call clergy.

The network that my colleague belongs to is huge and very different from the classic community and independent hospitals. A major difference is that community hospitals are supported by a community of volunteers. But on the positive side, a number of the member hospitals within my friend's partnership have well-established CPE internship programs. The CPE students provide a wonderful, invaluable blending of learning, experience and ministering to the patient. In addition, the professional chaplain's work can be supplemented by the field work education students, per diem chaplains, volunteers, and members of the clergy of various faiths.

A practical approach to staffing might be for the directors of pastoral care, or designees to gather data on why it is not a good practice to cut pastoral care budgets. Then, armed with data such as the number of patients who requested to be seen or were seen, not the number of beds in the hospital, the director may want to pursue the challenge of winning an increase in her budget.

Seeing every patient who enters a facility is not a realistic goal. I have always used an online referral system to visit the patients. They either self-referred upon admission, or other caregivers, including doctors, referred them to the chaplain. In this way I could organize my visits by emergencies, critical care, friendly visits and priorities such as expected length of stay. At times I sent handwritten notes to patients whom I missed, often clients known to me from previous hospital stays. Though letters are no substitute for being seen in person, this is a fine complementary ministry rooted in the Catholic tradition. My ministry to a few amyotrophic lateral sclerosis patients who could no longer speak was primarily through letters. This method did not seem time-consuming.

Beyond being a compassionate and an attentive listener and responder, I would describe myself as a practical, pragmatic, and frugal chaplain. The question was not how to stretch myself beyond what I had or could do, but how to function fully and well in the context of my ministry demands. I was a single, autonomous chaplain providing pastoral care to the entire hospital's shifting population of patients, workers, family, friends, and others. As much as possible, I worked within the hours I was compensated for. Although that meant I had to maintain the status quo, I helped to preserve the integrity and the continuity of my model of chaplaincy. It is unthinkable to minister as a Catholic lay chaplain without the help of volunteers of some kind. We use Eucharistic ministers to bring the Holy Communion to the sick. The Eucharistic ministers find it a privilege to bring the Body of Christ, and the patients in turn greatly appreciate the ministry. And of course priests provide the Sacrament of the Sick and confessions, the ministries that are reserved for them.

As a seasoned chaplain, I also supervised field work for students from area theological schools and seminaries. The field work students are as invaluable for delivering pastoral care as the CPE students. I have always said to them, "The patients you saw would have gone unseen if it weren't for you." However, I stressed that their primary responsibility was learning from their experience. By extension, we could also recruit and, I stress here, train, volunteer members of the parishes who support us as chaplains to help us visit the sick.

While summer lasts here in the Northeast and elsewhere, please, instead of worrying about the shrinking staff, while there is still time, recharge. Stretch yourselves on the beach by the busy ocean or by a gently lapping lake, or be caressed by the wind on a mountaintop.

Georgia Gojmerac-Leiner, BCC, is a chaplain in Natick, MA.

Eucharistic minister finds rewards in hospital setting

by Terry Supancic

What an honor it is to bring the Body of Christ to the Body of Christ. Distributing Communion at Mass and now at St. Joseph Health Center in Warren, OH, has enriched my life, and I hope the lives of others. Volunteering with a pastoral care team has given me insight into the ministry as well as the dynamics of ministering to one another. Including volunteers in this ministry lets me do the work of the disciples in a setting that is needed.

The chaplains are open and eager to share their wisdom and practical advice as we work to meet patients' needs. Being a part of a committed group has helped me to grow in my own spirituality and expand my confidence to share faith and prayer. The chaplains have taught me by example to respond to the patients, and also to know when to refer to them for more in-depth issues. As people struggle with illness or are facing death, we listen for cues that would signal a need to talk to a professional. Social workers as well as chaplains may be needed, as the healthcare system is ever changing. I may be the eyes and ears to help in a very important way as I go in and out of the patients' rooms.

As I enter the hospital, I ask God to be with me as I prepare to meet the challenges of the day. I ask that I may have the words to comfort and the patience to listen to those who are suffering. I ask that I will invite those who have been struggling with their faith to be open to the Spirit as we pray and share. Going to the tabernacle to get the hosts is a quiet time to say a prayer for all the work going on in the hospital. I try to pray, and act, in a way that gives dignity to all involved and praise to God, who makes it all possible. Walking through the halls is a reminder to all employees that we are all ministers to each other. Everyone is important to the mission of the hospital.

Entering a patient's room and washing my hands reminds me of Mass and linking this sick person to the greater community that I represent. Being a member of the Catholic Church unites us to all of the faithful. The introductions are brief, but the eyes of the patients say so much as we offer communion to them. All those in pain, those confused from being old, and those in joy from good news are grateful to have the opportunity to receive the strength that the Eucharist brings. The words of the Our Father bring comfort and open memories that bring them to a safe place to be with God. An inner light becomes brighter as we recite the prayer together.

This life journey that we all share is made better by the encounters we have with Christ. The ministry to help each other is done in so many different ways, and I am privileged to bring Holy Communion to those in the hospital. I encounter Christ through them.

Terry Supancic is an extraordinary minister of Holy Communion at St. Joseph Health Center in Warren, OH. Before retiring, she served as a pastoral associate at Blessed Sacrament Parish in the Diocese of Youngstown.

Certification Commission reviews recent interviews

by Mary Davis

As members of the NACC Certification Commission, we always look forward to their July meeting, because we get face time with the interview team educators, the group that advises the people responsible for interviewing members applying for certification.

The ITEs, well led by Carolanne Hauck, are a diverse group of passionate people, dedicated to ensuring that certification interviews are conducted in the light of the NACC's mission, vision, and values. They are constantly reviewing and enhancing their work with interview teams to provide considerate and competent interviews for certification applicants.

Our joint meeting time focused on the number of standards that may need clarification in an interview. The ITEs set goals for the coming year to enhance the ministry formation of interviewers, explore assessment of applicants' cultural competence in interviews, and to continue developing the role of the ITE within the overall certification process.

After meeting with the ITEs, the Certification Commission reviewed presenters' reports from recent interviews and the decisions to grant, deny, or offer another interview for applicants following discernment of the interview teams' recommendations. Materials for members' renewal of certification paperwork are likewise thoroughly reviewed, with decisions made to renew certification or request more clarity and information. Often these reviews spark lively conversation and deeply touch the hearts of the Certification Commission members. Our responsibility is not taken lightly, and decisions are made in the integrity of the NACC mission, vision, and values.

Some topics discussed at the July meeting include: retired certification renewal requirements; stewardship of certification-related expenses; potential for other certification levels; NACC glossary additions related to NACC standards; future implementation of new standards from the USCCB review; further refinement of the palliative care/hospice specialty certification competencies and process; and clarifying the roles of the Certification Commission chair and vice chair. We thanked Mr. Joseph Bozzelli, D.Min., and Sr. Julie Houser, CSJ, who are completing their second term on the Certification Commission, and look forward to new persons joining us in 2015!

While our meetings are very full and often intense, the fulfillment of volunteering for the work of NACC carries us forward and leaves us feeling more energized than we were when we arrived. If you speak with an interview team member, ITE or Certification Commissioner, please thank them for their part in ensuring that NACC lives out its values in the certification and renewal of certification process!

Congratulations to our newly certified members!

The following newly certified chaplains participated in a certification interview in May 2014 and were reviewed by the NACC Certification Commission at its July meeting. We are excited to welcome these 40 newly certified chaplains and celebrate with them the culmination of their certification process.

Mr. Robert Andorka, La Grange Park, IL
Sr. Regina Aviso, Carm.O.L., Seattle, WA
Mrs. Susan Balling, Butte, MT
Mrs. Karin Barrett, St. Paul, MN
Mr. Frederico Borche-Gianelli, Los Angeles, CA
Rev. Leonard Chuwa, A.J., Jacksonville. FL

Ms. Patricia Crowley, New Orleans, LA
Rev. Alejandro De Jesus, OSB, Augusta, ME
Sr. Mary Ellen Diermeir, SSJ-TOSF, Hatley, WI
Rev. Abayneh Gebremichael, Brockton, MA
Dr. Margaret Hardebeck, Covington, KY
Mrs. Helen Hofmayer, Northport, NY
Sr. Janet Husung, CSJ, Los Angeles, CA
Ms. Geri Jones, Richmond, VA
Rev. Jean-Ridly Julien, Stamford, CT
Rev. Donatian Kaigima, Anchorage, AK
Mr. Jesse Keane, Boulder, CO
Mrs. Marguerite Kronberger, Minooka, IL
Dr. Tina Lightner-Morris, Gaithersburg, MD
Mrs. Agnes Lugira, Woburn, MA
Mrs. Jennifer MacDonald, Bellingham, WA
Mr. John Mastalski, Redding, CA
Ms. Theresa McCarthy-Maynard, St. James, NY
Sr. Donna Maria Moses, OP, Los Altos, CA
Rev. James Ojo, Brookline, MA
Mrs. Mary Susan O'Keeffe, Bellerose, NY
Rev. Patrick Okwumuo, Billings, MT
Rev. Casmir Onyegwara, Washington, DC
Rev. Emmanuel Otiaba, Seaford, NY
Mrs. Marzena Przeszlo, Chicago, IL
Sr. Rita Radecki, OSF, Bryan, TX
Mr. Albert Rinaldi, Lakeview, NY
Mrs. Linda Rodgers, Ann Arbor, MI
Mr. Harrison Roper, Hewitt, TX
Rev. Mr. James Siler, Lake City, MI
Ms. Pamela Sipos, Shoreline, WA
Mrs. Angela Smerz, Kailua, HI
Rev. Joseph Tharackal, Hollis, NY
Mrs. Dawn Turpin, Wading River, NY
Rev. Clement Umoenoh, Bronx, NY

Song to the Caregivers

They listen to the deepest quiet of the soul no one
sees, except the Power that called them there.
Where the sound is hushed to a silent river of tears,
to share in the afterglow of new birth, or rejoice
in the celebrations of life's afterthoughts,
hindsights of forgiveness, sunlight of love,
paper moons of peace.

Oh yes, the prophetic voice sings along, with and for.
What is left unsung in the music of the spirit
of one lying there, perhaps breathless at the tempo
of the last notes?
What is the meaning of life for him, for her,
for the ones still in the circle, or for those who
had already left?

Two worlds, one soul, many souls, giving,
receiving, painful at times here.
But the joy is in the offing, an eternal promise,
still here, already there, not yet.

Stay in your dwelling in the desert, where all is
shed for the heart of the matter. Where to be
barren is grace; fullness, an overflowing gift.

Isabelita Q. Boquiren, BCC

Washington area offers plenty of sights, activities during 2015 conference

By Thomas J. Devaney and Victoria Lucas

President Harry Truman was wrong! He once said, "If you want a friend in Washington, get a dog." But when the National Association of Catholic Chaplains gathers in the Washington area next March, we will make Washington the friendliest town in the country – at least for that weekend.

Our location, the Hyatt Regency Crystal City in Arlington, Va., is a short walk from the Metro. From there you can journey to a city of stunning architecture, world-class museums, and monuments honoring the brave, the fallen, and the founders of our country. You can see the Capitol, the Supreme Court, and the White House if you enjoy politics and history.

If you enjoy the fine arts and history – which you can't escape in the District – you can explore the various Smithsonian museums. From the Museum of American History to the Air and Space Museum to the National Zoo to the National Portrait Gallery to the National Gallery of Art, each offers a unique view of the world around us, and the admission is free.

History becomes tangible when you visit sites such as Ford's Theatre, George Washington's estate Mount Vernon, or any of the monuments honoring our heroes. Remember that Arlington National Cemetery is located near our conference hotel.

Arlington, originally part of "10 miles square" surveyed in 1791 to be the United States' capital, is home to the Pentagon, the Marine Corps Memorial, and the Air Force Memorial. It offers everything from coffee houses to eclectic theater.

Nearby is historic Old Town Alexandria – home to cobblestone streets, trolley car tours, restaurants and shops, including the Daughters of St Paul bookstore. Old Town Alexandria is the location of St. Mary's Catholic Church, the first Catholic church in Virginia. Historic St. Joseph's Parish, which was established with the help of St. Katherine Drexel in 1915 for African-American Catholics of northern Virginia, is close to our hotel. Saint Joseph's is served by the Josephites, a religious community of Catholic priests and brothers committed to serving the African-American community, and is well-known for its fabulous and lively gospel choir.

Those who enjoy the outdoors can take a Potomac River boat tour, walk the C&O Canal Towpath, visit Rock Creek Park, and view the soon-to-bud cherry blossoms.

It was in Washington that the NACC began 50 years ago, and the Archdiocese of Washington just celebrated its 75th anniversary. Some important churches and shrines in the area are the Basilica of the National Shrine of the Immaculate Conception, Catholic University, St. John Paul II National Shrine, Cathedral of St. Matthew the Apostle, Franciscan Monastery of the Holy Land, Holy Rosary Church, Holy Trinity Church, and the Shrine of the Sacred Heart. If you visit any of these churches, you will also be in some wonderful communities of the District, such as Georgetown, DuPont Circle, Columbia Heights, and Foggy Bottom.

There are sports, too, in Washington. During March, the Wizards, Capitals, and the Hoyas of Georgetown play at the Verizon Center. Maybe you can see them play live; and just maybe, your favorite team is their opponent. The Verizon Center is in Chinatown, with many restaurants nearby.

So come to the NACC's conference March 6-9 to celebrate our 50th anniversary. Come and visit our history and heritage. Come to prove that the good President Truman was wrong.

Deacon Thomas J. Devaney, BCC, and Victoria Lucas, BCC, are the local arrangements co-chairs for the 2015 Conference Planning Task Force.

CPE Lite: Forming pastoral chaplaincy volunteers

by Austine Duru

The role of professional healthcare chaplains has continued to evolve. In recent years, this evolution has placed significant demands on chaplains to find creative ways to expand their reach without compromising care. Managers and directors of pastoral care services have also been pushed harder than ever to do more with less. In other places, the requirement by the Joint Commission to meet the spiritual needs of patients has stretched professional chaplains further. Relying on volunteers to meet this need has become common practice.

Volunteers provide an opportunity for professional chaplains to respond to the changes in their ministry practice that would otherwise be difficult to manage. The transformation of healthcare in the 1920s witnessed an equally transformative approach to theological education that began to focus on the "living specimen" or the human person as the subject of theology and pastoral education. This action-reflection model, now called clinical pastoral education, set the stage for healthcare chaplaincy as a profession.

The changes in healthcare in the 1980s gave rise to the term "pastoral care associates." These are specially trained volunteers who partner with professional chaplains to provide care to patients and families. These associates receive basic training and often work in close collaboration with and are supervised by professional chaplains.

Now, we need a different breed of chaplaincy volunteers. As professional chaplains react to the new demands in healthcare, certain areas of the traditional chaplain ministry will be inevitably relegated to chaplaincy volunteers. Chances are that the new breed of volunteers might have limited supervision and may be required to use social media and smart devices. They may be increasingly exposed to interdisciplinary settings and will require some knowledge of medical terminologies and corresponding interpersonal skills. The emphasis here is on formation, which focuses on intentional, ongoing development and learning.

Studies have shown, however, that volunteers feel alone in their work and could benefit from ongoing training and professional development. Institutions need to cultivate the identity of volunteers in their role as caregivers (Skoglund, 2006). But where does one find such a chaplaincy volunteer pool, and how do you keep these volunteers engaged? How do you justify using volunteers for ministry that was traditionally compensated? And how do you build commitment to the clinical and theoretical work that is called for? These are difficult questions without easy answers.

However, to be effective, any chaplaincy volunteer formation program must meet certain minimum criteria. To date, several pastoral care centers across the nation have developed stand-alone training programs, often in collaboration with volunteer services, to meet their unique local needs. There is an abundance of training manuals for volunteer chaplains in correctional facilities and penitentiaries, but only a handful of healthcare chaplain training manuals are available. Reviews reveal some gaps in the training programs, yet some hold great promise. Here is a sampling:

1. *Hands on Ministry: Texas Baptist Volunteer Chaplaincy Training Manual.*
Church Ministries, 1998. This is perhaps the oldest of the resources available for chaplaincy training. This resource is limited by its focus on Christian ministry and may not be effective in a diverse healthcare setting. Unfortunately this resource is currently out of stock.

2. *Volunteer Chaplain and Spiritual Support Training.*
Suncoast Hospice Institute, 2012. This downloadable self-paced manual, primarily for hospice and palliative care settings, is "a training program developed to assist chaplains and spiritual care volunteers to perform their responsibilities in caring for patients and families at the end of life. The manual also includes PowerPoint slides with facilitator notes to provide hospice and palliative care volunteer chaplain training, job descriptions, documentation forms and training resources" This resource has some advantages for those who work primarily with patients and families at the end of life, but the lack of a broader application imposes a huge limitation. Also, the price tag of $100 per download is cost-prohibitive.

3. *Health Care Chaplaincy Volunteer Handbook: A Training Resource.*
Church House Publishing, 2001. 184 pages. $49 This chaplain volunteer training resource published by the Chaplaincy (Health Care) Education and Development Group, UK, holds some promise. It gives a taste of how chaplain volunteers are trained in Europe. This manual is practical, simple and user-friendly. The price is reasonable. It builds on the clinical method and draws on theories of volunteer recruitment and retention. It could be adaptable across various pastoral care settings and parish ministry. However, most of the materials covered are rudimentary. I am not certain that this resource will be immensely helpful for preparing chaplaincy volunteers to respond to the changing needs of healthcare in the United States.

4. *Chaplaincy Care Volunteer Training Manual*.
Healthcare Chaplaincy Network, New York. 108 pages. $35 Of all the manuals surveyed, this recently updated publication offers the most possible benefit. It is suitable for a variety of clinical settings and lends itself to adaptation and modification. It will be particularly attractive to those who wish to standardize or reorganize their existing chaplaincy volunteer services program. It is strong on the theoretical framework and incorporates new healthcare and HIPPA laws.

Here is a brief outline of the *Chaplaincy Volunteer Training Manual:*

- Identifying Spiritual Distress
  Communication and Listening
    - Active Listening
    - Non-Verbal Communication
    - Responding Skills
- Understanding the Patient: Older Adults and Aging Issues, Individuals with Visual Impairments, and Individuals with Hearing Impairments Visitation
    - Outline of a Chaplaincy Care Visit
    - Initiating the Visit
    - Guidelines for Interacting with Patient, Family and Team
- Cultural Competency, Spirituality, and Religion
    - Assessing Your Own Cultural Heritage Exercises
    - Religious Diversity – Traditions on Life and Health
- Death and Grief
    - Tasks of the Dying Patient
    - The Family of the Dying Patient
    - Grief and Mourning
- Confidentiality
    - Confidentiality and HIPAA
    - Specifically for Chaplaincy Care Volunteers

This resource could be easily used as stand-alone material or as a core for a volunteer curriculum that incorporates other resources. Particularly helpful are the built-in tests that help volunteers self-assess around cultural sensitivity questions. The price tag of $35 makes it cost-effective. Above all, this manual gets closer to the idea of formation that was referenced earlier. It has been characterized by some as "CPE lite."

Chaplaincy volunteers will continue to play significant roles in the delivery of pastoral care across the nation. It is therefore important to develop a robust formation program to equip these volunteers to meet the increasing complex demand in healthcare chaplaincy.

Austine Duru, BCC, is director of mission and pastoral care at St. Elizabeth Regional Medical Center & Nebraska Heart Hospital in Lincoln, NE.

Bibliography

Flannelly, K. J., Handzo, G. F., & Weaver, A. J. (2004). Factors affecting healthcare chaplaincy and the provision of pastoral care in the United States (link unavailable). Journal of Pastoral Care and Counseling, 58, 127-130.

Flannelly, K. J., Weaver, A. J., Smith, W. J., & Oppenheimer, J. E. (2003). A systematic review on chaplains and community-based clergy in three palliative care journals: 1990-1999. American Journal of Hospice and Palliative Medicine, 20(4), 263-268.

Munro, G. (2013). A chaplaincy volunteer visitors service. Health and Social Care Chaplaincy, 4(2), 29-31.

Skoglund, A. G. (2006). Do not forget about your volunteers: A qualitative analysis of factors influencing volunteer turnover. Health and Social Work, 31(3), 217.

VandeCreek, L., Siegel, S., Gorey, E., Brown, S., & Toperzer, R. (2001). How many chaplains per 100 inpatients? Benchmarks of health care chaplaincy. Journal of pastoral care, 55(3), 289-301.

Weaver, A. J., Koenig, H. K., Flannelly, K. J., & Smith, F. D. (2004). A review of research on chaplains and community-based clergy in the Journal of the American Medical Association, Lancet, and the New England Journal of Medicine: 1998–2000. J Pastoral Care Counsel, 58, 343-350.

Cast your vote for the NACC's Board of Directors

We invite you to vote in this fall's election for the open seats on our National Association of Catholic Chaplains Board of Directors. The membership will fill two elected seats on the NACC Board.

The NACC Nominations Panel, the Governance Committee, and the Board of Directors worked conscientiously to discern leadership needs, seek board applicants from our membership, and choose candidates who bring a wealth of experience and expertise to the Board. We are grateful to those who offered to be candidates.

The Board of Directors is pleased to present to you two candidates for the two open seats. We are communicating with members about this election via email. NACC members without email addresses will be sent a letter to alert them of the voting eligibility, timeline and process.

Eligibility
Members in the following categories are eligible to vote: Board Certified Chaplain, Certified CPE Supervisor, Missionary, Retired, and Emeritus. Members in the following categories are not eligible to vote: Student, Associate, Ministry Volunteer, Inactive Board Certified Members.

Timeline
The voting time period will be three weeks, from Tuesday, Sept. 2, 2014 through Monday, Sept. 22, 2014.

Process
You will need the email sent to you from the NACC office on September 3 or 4, 2014. The subject line of the email was "IMPORTANT - your voter code for the 2014 NACC Board of Directors' Election." Note that if we don't have your email address, or if you don't use email, you will have been sent an actual letter.

Inside the email or letter you will find your **voter code**.
Your code will look something like this:
46611,398,youremailaddress@generalhospital.com

Go to www.ballotbin.com and enter your voting code into the box at upper left, then click "go vote!" You will be shown a ballot with candidate details (just click to expand the details). Make your selections, then click "done."

Ballotbin will track who votes based on the unique voting codes, thus eliminating any chance of multiple voting. Be assured your vote is secure and completely confidential.

If you cannot vote online, please visit www.nacc.org/vision/2014-Sep-Oct/2014ballot.asp for a printable ballot, print it, fill it out, and send it to: NACC, 4915 South Howell Avenue, Suite 501, Milwaukee, WI 53207. Please check the box and include your printed name and membership number that indicates you permit NACC staffer Cindy Bridges to submit the vote on your behalf.

Thank you in advance for participating in this election. We rely on our Board for strong, creative leadership, and your role in the Directors' selection is vital.

Sincerely,

John M. Pollack, M.Div., BCC
NACC Chair, Governance Committee