The New Competencies: What you need to know

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Revised competencies took a lot of work and collaboration

By David Lichter
Executive Director

This issue of Vision is dedicated to the revised Common Qualifications and Competencies for Professional Certification and our specific NACC qualifications. We appreciate so much our members who have contributed articles highlighting some of the specific new competencies. In this column, I will provide some contextual observations about the revised CQCs, and the NACC additions.

As you might recall, we started this process in late 2013, since the NACC needed to submit for re-approval to the USCCB Subcommittee on Certification for Ecclesial Ministry and Service. In early 2014, the NACC Standards Commission completed a revision of the specific Catholic standards based on USCCB National Certification Standards (see www.nacc.org/certification/nacc-certification-competencies-and-procedures/important-background-nacc-certification-competencies-procedures/). These revisions were approved by the NACC Board of Directors in April 2014 and submitted to the USCCB in July 2014, along with our entire NACC 2014 Report. These were approved by the USCCB SCEMS in September 2014. I refer you back to the January-February 2015 Vision issue with my article “Questions and answers about the revised NACC Standards” that provides the background for those specific Catholic standards added to the 2004 Common Standards.

However, with the 2015-2016 collaborative work on the revision of the 2004 Common Standards with our strategic partners (ACPE, APC, CASC, and NAJC) and the subsequent renaming and renumbering of what became the Common Qualifications and Competencies, we also had to renumber those specifically Catholic competencies. You can now see them by visiting this page of the website that offers several background documents: www.nacc.org/certification/nacc-certification-competencies-and-procedures/important-background-nacc-certification-competencies-procedures. Click the live link to the document noted as These NACC additions to the CQC’s are highlighted in yellow in this document.

In the March-April 2017 Vision, I wrote (www.nacc.org/vision/march-april-2017/partnerships-help-nacc-accomplish) about the exceptional partnerships with ACPE, APC, CASC, and NAJC as we revised the 2004 Common Standards that have become the CQCs. I am excited about the ongoing collaboration with APC as our
two Certification Commissions continue to explore together ways to strengthen one another’s processes. In fact, those responsible for the APC’s Hospice and Palliative Care Specialty Certification (bcci.professionalchaplains.org/content.asp?admin=Y&pl=42&sl=42&contentid=45) and our NACC Advanced Certification of Hospice Palliative Chaplaincy (www.nacc.org/certification/nacc-certification-competencies-and-procedures/hospice-palliative-care-achpc-advanced-initial-certification) have begun to explore how our members can better prepare themselves for this specialty certification. This effort includes reviewing/revising the competencies together; an online education format for part of the requirements; and exploring approaches to evaluating one who has prepared for this specialty certification.

Finally, our Certification Commission, our Interview Team Educators, and our office staff, Ramona Zeb and Jeanine Annunziato, have dedicated themselves to not only determine how best to educate you, our members, on the revised Qualifications and Competencies, but also to improve the entire certification process for all involved. We all want well-prepared applicants to submit their materials with a confidence of being ready to be certified, and to have well-prepared interview teams who will provide a high-quality, consistent, fair interview experience.

I hope you will join me in thanking our many members who have dedicated themselves to our certification process. Ultimately, we want to ensure the highest quality spiritual care to the most vulnerable — those seeking the healing ministry of Jesus through us.
Skill at assessments carries many other benefits

By Carolanne Hauck

More than ever, chaplains need to convey their contribution to patient outcomes and experience. Professional documentation of the chaplain assessment is a good place to start, and we are fortunate that, as a profession, formulating and utilizing spiritual assessments are competencies required for certification:

PAS6: Formulate and utilize spiritual assessments in order to contribute to plans of care.

One very positive change that came about through the implementation of the electronic medical record for us at LGHealth/Penn Medicine was finding a way to capitalize on the change in the way we document our work. Chaplain documentation on the EMR has proved to be an excellent tool for chaplains to increase the level of professionalism of their notes, with the added benefit of recognition of healthcare professionals and appreciation for chaplains’ work.

Before EMR, handwritten notes on the patient chart were not easily accessible, and we often wondered if our notes were even read by other staff. To be honest, we did not focus much of our attention on our notes before the plan to implement electronic documentation in our chosen EMR, Epic. Planning for Epic made us assess our work and, more importantly, challenged us to find a better way to convey our contributions to patient well-being.

A well-written spiritual assessment provides insight into the values, spiritual risks, struggles, and resources that a patient brings to the current hospitalization. An understanding of what is meaningful to the patient provides all staff with the opportunity to care for the patient holistically.

There are many very good options for how to write a spiritual assessment. As we searched for what would work best for us, and through trial and error, we devised our own template. Assessment is just one part of our documentation. The addition of patient Goals, chaplain Interventions, Outcomes, and eventually Plan, was the best way to sufficiently convey the chaplain contribution to patient care.

Below is a copy of the template used for each patient visit, with a brief explanation for the chaplain’s reference of what to include, as well as an example of a completed note. The descriptions are very helpful when staff members feel stuck and when teaching interns and residents how to document on the plan of care. Of course, the template that is used on the chart does not include the descriptors.
Plan of Care Note – Chaplaincy Care & Education

(How did you select this pt? i.e. consult from [name], [title]; self-initiated based on…; pt requested visit; etc. Delete this parenthetical guide prior to filing!)

Assessment
(in this section – identify the spiritual risks, concerns, or struggles as well as the spiritual resources that the patient and/or family bring to this current hospitalization. Consider these areas: life review, hopes, values, fear, meaning purpose, beliefs about afterlife, spiritual or religious practices, and cultural norms, beliefs that influence understanding of illness, coping, guilt, forgiveness, loss history, and life completion tasks. Delete this parenthetical guide prior to filing!)

Goals for Spiritual Care
(in this section – Given the above assessment, what are the goals for the patient or family in this hospitalization? Delete this parenthetical guide prior to filing!)

Interventions
(in this section – How did you work toward the Goals in this visit? Delete this parenthetical guide prior to filing!)

Outcomes
(in this section – What were the results of your visit? How did patient or family respond? Describe behavioral changes that indicate response. Was there progress toward the goals? Delete this parenthetical guide prior to filing!)

Plan
(If there more work to be done toward the goals? If so, how will that be done? Follow-up? Delete this parenthetical guide prior to filing!)

(article continues on next page)
Once we became familiar with using the template, we looked for ways to add metrics to our work for the purposes of quality improvement. For example, it became important to
evaluate the quality of assessments. The writing guide for assessments provided the means for self-evaluation as well as evaluation by the director of the department. Below are examples of two metrics that we have used.

**Goal I**: 95% of documentation (assessments) address two or more spiritual assessment criteria.

**Goal II**: 80% of documented outcomes directly linked to goals.

This process has helped chaplains evaluate their own notes more fully and has greatly improved the professionalism of their spiritual assessments. But initially, the metrics were well below desirable levels. Percentages were 70% for Goal I and 45% for Goal II. At the start, we found that chaplains struggled to adequately link outcomes and goals. Asking ourselves about the barriers fostered great conversations about the work and eventually helped us formulate an education plan that quickly improved our efforts. Since then, charts are randomly reviewed once a week and the metrics are posted and shared with the department. As of late, percentages for both goals have met and exceeded the desired outcome!

Over time, we have also added a chaplain documentation template for follow-up care, and one for family care. Staff chaplains have also devised a “Smart Phrase” tool that gives the chaplain easy access to a list of interventions and potential goals. This tool comes in handy when the chaplain is very busy or might need a bit of help with his or her writing.

Most notable, however, is the evidence that others are using our notes. Chaplains see references to their assessments in the notes of social workers, case managers, RNs, and the palliative care team. Recently, a young pregnant patient lost her baby in a car accident. Because of the mother’s extensive physical injuries, she recovered on a unit that does not typically care for patients with loss. Through the chaplain documentation, staff caring for the patient found many helpful ways to give the kind of sensitive care that the patient needed. The chaplain’s documentation conveyed what the patient found meaningful in the midst of her loss as well as tools that the patient was using to cope. Members of the team thanked the pastoral care staff often for the helpfulness of their notes and stated that they felt more prepared to care for the unique needs of the grieving patient.

Providing a good spiritual assessment is one of many tools that chaplains use to contribute to patient and family experience and outcomes. Documenting in a professional manner provides concrete evidence that what we do matters.

*Carolanne B. Hauck, BCC, is director of chaplaincy care and education and volunteer services at Penn Medicine Lancaster General Health in Lancaster, PA.*
Facilitation skills necessary in many settings

By Dan Waters

The family meeting was taking place in a private consultation room just outside the ICU, and the attending physician and I were co-facilitating. The patient was not responsive. Several family members had come to grips with the situation and were prepared to allow nature to take its course with no further interventions. The attending physician clarified the clinical information, and all clinicians were on the same page.

However, one grandson who had been estranged from the patient was extremely vocal about not giving up. As the chaplain, I was able to create a space where the grandson could talk about his guilt and sadness and begin to process emotions. The family offered the young man words of support. The process took longer than one family meeting, but within 24 hours, interventions were stopped, and the patient was moved to the palliative care room and eventually to a local hospice.

This kind of group facilitation is becoming more important in a chaplain’s duties, and the revised competencies reflect that. PPS 9 reads, “Facilitate group processes, such as family meetings, post-trauma, staff debriefing, and support groups.”

Many readers will remember the standards for certification of past years, which did not specifically talk about group facilitation, although Standard 302.5 discussed an understanding of group dynamics. In 2015, the NACC adopted Standard 304.11: “Facilitate group processes, such as family meetings, post trauma, staff debriefing, and support groups, and provide conflict management as needed.” Competency PPS 9 is focused and has been added by our cognate partners. Group work has been a part of CPE programs in the past, but the need for clinical application is growing.

An important starting point is to clearly identify the purpose of the group. This may seem obvious, but a clear understanding of purpose can help the chaplain identify resources, reflect upon chaplaincy skills needed, and assess the dynamics present.
A spirituality group, for instance, may begin with a focus on forgiveness, and resources may include relevant scripture, an object lesson, or a story that will resonate with the participants. Once, when I mentioned the word “spirituality” to the group I facilitated in the dual diagnosis unit, one patient, Don, abruptly stood up and left, saying, “This is NOT what I want to do today!” I had just started again when Don, just as abruptly, came back into the room. Through the course of a story and discussion around healing light from the places where one is most broken, Don began to relax and tell his story: It was the anniversary of his dad’s death seven years earlier. Each of the previous years, Don had spent the day drunk and ended up incarcerated. But by the end of the session, Don proclaimed, “This is NOT what I expected, and this is the best I’ve felt in a LONG time!” I had to admit that this was not what I expected either!

A trauma debriefing in the emergency department might focus on the emotions of a difficult case and include members of a multidisciplinary team that provided care. Recently, I was called on to facilitate a voluntary debriefing session in our community hospital’s Level 3 Emergency Department, which had experienced five pediatric deaths or near-deaths due to abuse in less than a month. Many of the same staff members had provided care in these cases and were overwhelmed with moral distress. The session took place in the ED break room, so that employees would not be far in case they were needed, but the door was closed to provide some privacy and to shut out some of the usual din. Several disciplines were present, and the process began with a recalling of the events. Statements of what each person observed unfolded into statements of the emotions observed and then to reflection on personal emotions; some shared their own spiritual struggles after these events. Each participant voiced healing in the process of deep sharing with colleagues.

In any group setting, a facilitator is challenged to have an awareness of the creative process, cultural differences or traditions, the value of collective wisdom, the need for mutual respect and confidences, and family systems. The facilitator has the task of keeping the group focused on the purpose. A participant in a spirituality group may want to take over with their own personal religious views, or a family member at an ICU meeting may try to focus the discussion on past hurts or a perceived hidden agenda of another family member.
Practical matters in any group may include identifying an appropriate location and setting, respecting time limits, bringing awareness to protocols or HIPPA, or including a co-facilitator.

Setting an agenda will flow from the purpose of the group. A family meeting may start with identification of the patient’s wishes, and resources may include advance directives and doctors, nurses, and other clinicians, as in the opening example. Debriefing of a trauma may begin with a recounting of facts as they are known, allowing space for clinical information but then challenging participants to move into observed emotions and then deeper into personal emotions or spirit.

The facilitator ends the group when appropriate. The end may be set by respecting an agreed-upon time limit, an awareness of the discussion repeating itself beyond need for clarification, an agreement on a plan of care, or a realization that the group has addressed the intended purpose as completely as possible.

Matthew 18:20 says, “For where two or three are gathered together in my name, there am I in the midst of them.” The spirit may take on a skin color different from ours, follow a process that we did not imagine, or bring forth an unanticipated wisdom, but we are challenged to be open to the spirit in each group.

*Deacon Dan Waters, BCC, is the Spiritual Care Coordinator and a staff chaplain at Mercy Health St. Charles Hospital in the Toledo, Ohio, area.*
Understanding the business of healthcare

By Tim Crowley

Almost a year ago, I presented a webinar for NACC membership on “What every chaplain should know about the business of healthcare.” Since then, the looming uncertainty over coming changes in the healthcare landscape has only grown.

With a system ripe for reform, the chaplaincy profession must make our case for how our services contribute to safe, efficient, effective and improved healthcare services. What we do makes a big difference, as healthcare is about much more than medical care. The spirit needs healing and care as well, and it’s our role to lead that effort in our organizations.

As a retired hospital executive and a recently minted chaplain, I’ve been asked to reflect on how our newly required competencies as chaplains interplay with organizational culture and business principles.

As a reminder, the revised standards of practice for chaplains include Standard 15, “Business Acumen: The chaplain values and utilizes business principles, practices and regulatory requirements appropriate to the chaplain’s role in the organization.” NACC (and the common standards) include standards 305.1, “Promote the integration of Pastoral/Spiritual Care into the life and service of the institution in which it resides,” and 305.3, “Articulate an understanding of institutional culture and systems, and systemic relationships.”

Standard 15 means that as a practicing chaplain, you need to be reasonably well versed in the business of the healthcare industry and how your own organization is regulated and financed. I suggest reading at least one general healthcare trade publication on a weekly basis (free subscriptions at HealthLeadersMedia.com or BeckersHealthcare.com) and have it come straight to your email account, so it becomes your routine. Ask your finance department to do an in-service for you on what you should know about the finances of your organization (and the issues are different in acute care, long-term care, hospice/palliative care, clinics/physician practices). Also, ask what you can do to make your organization more financially healthy. Reducing length of stay (cost reduction) or improving patient satisfaction scores (enhancing revenue) are prime examples, but there are many more. Ask your executive leadership how they view your contribution, and determine if they understand what you do.

Meet with your clinical leadership and educate them on the contributions you can make to an interdisciplinary care team — if you aren’t doing that already. Ask your compliance department about regulation. Interestingly, the leading accrediting agency for U.S. hospitals, The Joint Commission, pays little attention to the provision of spiritual care on their surveys, and the cognate groups are addressing with TJC how their surveyors would recognize consistent, effective spiritual care. To the best of my knowledge, chaplaincy is required by Medicare only for hospice providers. Unless we work for a religiously based organization that has spiritual care in its mission, we are optional.

Standard 305.1: In your own organization, you need to be able to articulate the value of your pastoral/spiritual care contribution to the overall effort. Remember, almost all of us work in environments that are in an ongoing quest to reduce expense. If you read Vision regularly, you know that we have been encouraged to become an active part of the interdisciplinary clinical team (see www.nacc.org/vision/july-august-2017), to chart our work (www.nacc.org/vision/2015-Jul-Aug) in the medical record (and help our colleagues understand its value), and to prove our contribution through participation in research around our profession (see www.nacc.org/vision/2013-Mar-Apr). A critical aspect of this research is having reasonable, reliable measures of the quality and outcomes of the work
we perform. In my hospital career, I heard far too many healthcare executives suggest that a full-time pastoral care department is a luxury, so why don’t we just ask the volunteer community clergy to take care of the spiritual care needs. Uninformed positions require education.

Standard 305.3: We have a vital role to play in many aspects of the culture of our organizations, from spiritual support and active listening with patients/residents and their families; to our own staff and physicians; to assistance in conflict resolution; to guidance with end-of-life decisions; to educating other members of the team to recognize spiritual distress; to grief support; to ethics issues; and religious services and celebrations. While we are doing this work for which the Lord has called each of us, we need to articulate its importance to our health system leaders.

I am proud to call NACC my new professional organization, and pray for our continued success.

*Timothy J. Crowley is a staff chaplain at Twin Lakes Senior Living Community in Montgomery, OH, and is a retired hospital executive and a life fellow in the American
Summer institute makes research more accessible

Editor’s note: One of the new qualifications and competencies for certification is research literacy. As part of the ongoing Transforming Chaplaincy Project, several NACC members recently participated in a conference on pastoral care research at Rush University in Chicago. Two of them, Theresa Utschig and Kathy Klocek, agreed to share their reflections with Vision.

By Theresa Utschig

A new branch of chaplaincy has been developing quietly but steadily over the last few years: chaplaincy research. I recently had the good fortune to participate in the Chaplaincy Research Summer Institute at Rush University Medical Center in Chicago. Funded by The John Templeton Foundation, CRSI is part of “Transforming Chaplaincy: Promoting Research Literacy for Improved Patient Outcomes” project. CRSI not only allowed me to meet chaplains engaged in research, it but also helped me to understand why it is so important.

My own journey toward understanding and using spiritual care research began when my manager included me in our Research Committee. We were tasked with helping our department chaplains to become more research literate; educating ourselves about chaplaincy research and best practices; and exploring whether we could do our own research as a department. Finding, understanding, and presenting research articles was a challenge until we became familiar with our medical college and online resources, and found a statistician to help us navigate the charts found in the articles. A year later, we now have a quarterly journal meeting at which we present and discuss journal articles.

CRSI brought home to me again some of my own reflections on chaplaincy over the years. These are some of the tasks that we will need to focus on as we move forward in chaplaincy research:

1. **Informing the medical community about what we do.** Our healthcare institutions may or may not understand what we as chaplains contribute to the total healthcare picture. Some of us may even need to prove that we contribute to an institution’s bottom line. In light of this, we need more ways of communicating what we offer to patients/families/staff as well as the impact of our work on the people and institutions we serve. I hope and believe that chaplains in research will help us to move in this direction.
2. **Finding allies/partners in the medical community.** Many chaplains describe themselves and their role using language that is both liminal and communication-focused: “bridge,” “mediator,” “liaison,” “interpreter.” As we help our patients and families to navigate a possibly overwhelming emotional and spiritual terrain, we may also find ourselves addressing a communication gap between a vulnerable patient or support person and the medical staff. Arguably, we need allies as we provide care to patients. How often do we think to communicate this to others on the interdisciplinary team who could help us? The interdisciplinary team functions better when we are all on the same page, or (hopefully in the future) studying the same chaplaincy research.

3. **Articulating what we do.** Many of our chaplaincy departments have electronic charting tools to help us record the emotional and spiritual resources of the patient/family, the intervention, the outcome, and the patient’s plan of care. Have we also taken the time to lay out a catalog of chaplain interventions and how we used them during a visit? Let us make the effort to write down the many things we are doing, including why we made particular choices during a conversation. Why is it so important to spell this out? I think the answer lies in our accumulated wisdom and the gifts of our trade: We have years of experience doing this transformational work with people. Making this available to those within and outside our field would help address the needs of our patients and families. It would also help us to continue to define the contribution of chaplaincy to the institutions we serve.

4. **Sharing best practices with other chaplains.** Chaplaincy is changing as the needs of our patients and families evolve. We are collectively serving a population that is more predominantly secular and less religious (more “nones”). Are we taking the time to find out what other chaplains are grappling with in their environments? How are they describing their work? What tools are they using to help themselves? How are they addressing the move to outpatient service? How are they addressing the stresses of the staff? What about your own work? Have you been developing something that would really help another chaplain/institution? In our ever more complex environment, we need more information sharing. As one of my colleagues at the CRSI pointed out, what if we were to publish our findings in medical journals and not only in chaplaincy journals?
5. **Passing on our skills to new chaplains.** Experienced chaplains are uniquely positioned to contribute to the education of new chaplains. Are we taking the opportunity to pass on our skills? What if we were to write more about what we are doing — the reasons we have created certain tools; our interventions; the influences on our thinking; how spiritual development happens in hospital environments; and how our works helps the spiritual transformation of patients and families as they navigate illness and wellness? And what if our departments would budget time for reflecting on our work and passing it on to others, or for doing research or quality improvement projects?

Transforming Chaplaincy’s CRSI helped me to see more clearly the issues around chaplaincy research, and reinforced for me that we as chaplains need to retain our own unique and often unmeasurable presence in the organizations we serve. At the same time exploring our work and developing chaplain researchers is an exciting move for the future of chaplaincy.

*Theresa Utschig, BCC, is a chaplain at Froedtert and the Medical College of Wisconsin in Milwaukee, WI.*

**By Kathy Klocek**

My interest in chaplaincy research began at the NACC conference in St. Louis in 2014, when plenary speaker Dr. Tracy Balboni described her career. Then at the conference in Chicago two years later, I heard George Fitchett discuss chaplaincy research. I could see all the possibilities for spiritual care to prove, in terms that medical staff and administrators could understand, the value of what chaplains share with patients, their families, and hospital staff. Spiritual care could be fully integrated into healthcare, bearing amazing results for patients and everyone who cares for them.

I began to collect articles on spiritual care, which proved what I already knew from my own practice — a large percentage of patients wanted and needed spiritual care but were not receiving it. At this point I was hooked on research. Working in a hospital that had its own research facility made me think that some people might be interested in teaming up with me to do research on spiritual care’s positive effects on patient satisfaction and outcomes.
I was happy to receive an NACC scholarship to the first ever Chaplaincy Summer Institute for Research. The conference offered all the basics that I needed to know. Opportunities to network were plentiful, allowing me to discuss ideas and plans with experienced researchers as well as neophytes. I made valuable contacts that will be a source of additional information as I begin to develop plans for chaplaincy research at Magee.

One of the surprising things that I took home was that research is not always cold and dry but can have a big heart. One of the presenters, Katherine Piderman from the Mayo Clinic, shared her work, “Hear My Voice: A Spiritual Legacy Process for Those at the End of Life.” Kate said, “Our mission is to provide an innovative, compassionate, and respectful opportunity for individuals with advanced diseases to prepare a spiritual legacy based on their beliefs, values, and life-learned wisdom in the context of a spiritual care relationship with a chaplain.”

On the last day of the conference, Jeanne Wirpsa from Northwestern University shared her current research project, “The Role of the Chaplain in Medical Decision Making.” I could see how she had applied all the things that the conference presenters taught us, showing how it all can come together. What she said gave me hope that even I could do chaplaincy research.

When I got back to Pittsburgh, I met with my research team and we began to form plans for a pilot quality improvement project — our first baby step in chaplaincy research.

I am grateful to NACC for giving me the opportunity to expand my professional horizons for the good of the patients and their families we serve.

*Kathy Klocek is a chaplain at Magee-Womens Hospital of University of Pittsburgh Medical Centers, Pittsburgh, PA.*
Understanding organization’s culture helps to cope with change

By Michele LeDoux Sakurai

In this climate of ongoing change, more voices bemoan the shifts in healthcare. It often comes as, “When the sisters were here, ...” or, “But we have always done it this way,” or, “Where is the mission in this?”

What many staff/caregivers don’t understand is that realities outside the local setting often dictate change. For instance, the Centers for Medicare and Medicaid Services came to one of our sites to visit the long-term care unit. They found that although the door from long-term care to the chapel required a key for entry, the door from the chapel to the outside was not locked. This meant that an unattended resident in the chapel could wander into the street and be placed at risk. CMS now requires this door to be alarmed, and this is causing great angst for those who attend weekly Mass from the community. The community members view this change as lacking hospitality, for it now requires friends/family to use a different (and less direct) entry to the chapel. Even when the rationale is explained, staff and guests alike still struggle to understand. This isn’t how they have historically experienced mission.

This is but one example of new expectations or rules, and employees are feeling the burden and the consequences. Yes, everyone is doing more with less, and as the future impinges on the present, staff seem to be always having to let go of the past. As a result, chaplains are more often being invited to hear and respond to the distress. Chaplains are trained to be empathetic, but it is not enough to rely solely on presence.

Learning to cope with this kind of change is one purpose of the new competency 305.3, “Articulate an understanding of institutional culture and systems, and systemic relationships.” Chaplains who are attuned to an institution’s bigger picture, as well as the concerns of the person in front of them, can help but produce better outcomes for everyone.

Two months ago, the chief nursing officer called me into her office. She shared with me that the chaplains’ empathy was helping to embed the nurses’ sense of victimization. That made me aware that chaplains must become more conscious about how our responses are being read. Even silence can be read as agreement, and this can lead to misunderstanding.
The training of chaplains places them in the perfect position to help staff move toward empowerment. Through reframing, we do this on an ongoing basis with patients. To provide staff support, this simply means transferring these skills to staff interactions. A model that might be helpful is one that begins with the empathetic response by the chaplain, “It sounds as if this has been hard for you.” The chaplain then moves to help the staff person identify their own strengths and options, with questions such as:

1. You (the staff member) have identified the frustrations of this change, so how are you choosing to respond?
2. Do you understand the reason for the change? What do you need to feel comfortable moving forward?
3. What tools do you have to address these frustrations?
4. Have you spoken with your supervisor? (If the staff balks at this question, then ask questions 5-8.)
5. Sometimes these conversations are better placed in a larger setting. Have you considered taking it to your unit-based council?
6. What are the barriers that keep you from moving your concerns forward?
7. Would the employee/caregiver assistance program be helpful at this time?
8. Would HR be useful in this conversation?

If the staff person indicates only dissatisfaction and no positive response, invite him/her to consider these questions. A staff person who persists in discontent may be in the process of a discernment to a different place. Where do they find themselves being pulled? Is there a greater good that they need to consider? Each of us is called in unique and wonderful ways. So, too, are our institutions. We live on the edge of uncertainty and mystery. We live in faith that our service and voice can make a difference. This requires resilience, prayer, and trust in the words of our most gracious God.

“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)

*Michele LeDoux Sakurai, BCC, is manager of spiritual care at Providence Health Care-Stevens County in Colville, WA.*
NACC certification: Meeting the hardest competencies

By Mary Davis

Each year, the NACC Certification Commission tracks the competencies that are most frequently cited as “not met” when applicants are not recommended for certification following their interview.

We are concerned that the first several competencies cited (with the highest number of citations) reflect basic Level 1 CPE objectives: articulating how feelings, etc., affect practice; identifying one’s strengths and limitations in the provision of care; using pastoral authority; establishing, deepening, and concluding pastoral relationships; and building peer relationships. The remaining competencies are focused on ethics, human development, providing general spiritual support and support within grief and loss, and establishing interdisciplinary relationships.

On the one hand, it might be easy to see why an applicant would not be recommended if such basic competencies were not adequately addressed or assessed as not met. On the other hand, how can those who do not meet the competencies listed above meet the remaining competencies or be assessed as having met them?

The Certification Commission has reviewed and discussed these findings yearly, often in consultation with the Board of Directors. To learn more about how this is occurring, we sought input from those most affected by these outcomes: the applicants, the interviewers, and the interview team educators.

Applicants, interviewers, and ITEs offer feedback through post-surveys on a number of topics related to the certification process. From applicant feedback, the Certification Commission determined that these competencies could be bolstered through more specific prompts and questions within the Narrative Writing Guide. To this end, commissioners have taken specific competencies and are editing and drafting new questions/prompts for this document.

Discussions at ITE meetings about the competencies most frequently cited as unmet led to enlightening discussions about the competency language, cultural nuances affecting demonstration of competency, and assessment expectations of interviewers. One example is the difference between assessing for self-reflection on the part of the applicant and expecting this to be manifested through self-
revelation. The ITEs have reinforced their preparation and education of interviewers around the understanding and assessment of these competencies.

Those who have been certified for some time might find it a useful exercise in approaching their peer review for renewal of certification to do a self-assessment of how they meet today’s competencies. Asking their peer reviewer for feedback on how closely they meet today’s competencies would also enrich and deepen the peer review experience.

The Certification Commission will revisit the list of competencies cited over the next two years to see if the additional education by ITEs, the amended writing guide, and ongoing education through pre-certification webinars and conference calls have helped more of our members succeed.

Mary D. Davis, BCC-S, is the group director of CPE for CHRISTUS Health and an ACPE-certified educator for the CHRISTUS Santa Rosa Health System CPE program in San Antonio, Texas.
What does endorsement for ministry mean?

By David Lichter  
Executive Director

This issue of Vision is dedicated the revised Qualifications and Competencies for Certification. You will find many articles that explain the background and importance of new competencies. However, in this column I want reflect on one qualification, not competency, that remains at the core of chaplaincy for our Catholic members: endorsement by one’s local ordinary.

As you know well, the NACC was founded by the U.S. bishops in 1965 to provide support and certification for those serving the aging, ill, and dying. And the NACC mission statement highlights the nature of our ministry as ecclesial, “to continue the healing mission of Jesus in the name of the church.”

When our mission statement was carefully crafted in 2007, there were divergent opinions about whether to include “in the name of the church” in the mission statement. Wasn’t it enough to state, “continue the healing mission of Jesus”? But earlier, Bishop Dale Melczek had offered a clear perspective on what this means. “The NACC offers an enormous advantage to the church in assisting the bishops in the oversight of this vital ministry,” he wrote in 2005. “It also assures the people whom we serve that those who minister to them in behalf of Jesus and his church are grounded in Catholic theology, adhere to the ‘Ethical and Religious Directives,’ and extend the ministry of the church with the formal approval of the bishop.”

As a ministry of the church, we are not sent nor do we minister on our own. So from where does our “authority” come? Religious faith traditions answer this question in many ways. For Catholics, does it flow from our baptism and confirmation, or from our participation in the ministry of the bishop who receives his authority from his sacramental ordination? The answer is “yes.” Our vocation for ministry flows from our baptism and confirmation, and then this personal vocation still goes through a discernment and affirmation process by the church approved by the bishop(s) that is structured in some way.
Once this discernment and affirmation process is concluded, what next? The bishops’ document on lay ministry, Co-Workers in the Vineyard of the Lord (www.usccb.org/upload/co-workers-vineyard-lay-ecclesial-ministry-2005.pdf), makes it clear that every local ordinary reserves the right to “review the credentials of and meet with a candidate before an appointment is made.” The terms authorization and commissioning and not endorsement are used in this document.

We realize that an endorsement is not an appointment, because, in most cases, our NACC members are not working in ecclesial institutions that are under the direct diocesan jurisdiction of the bishop. The healthcare or other institution hires our chaplains, although in some cases, a bishop might appoint a priest or other minister.

Also, endorsement is not the same as authorization. While authorization is defined in “Co-Workers,” the concept of endorsement within the church does not have a commonly accepted meaning. The Catholic Church’s lack of consensus on its meaning is not unique. Having participated some years ago on a Spiritual Care Collaborative Task Force on Endorsement, I recognize that the term is defined differently by different faith groups.

Still there are some common features: It is not a commissioning or empowerment, but more a declaration of good standing with the Church, and vouches for the disposition and or character of a person. I believe most bishops and religious superiors would understand endorsement in this way. The bishop recognizes the NACC certification process as the “discernment and affirmation process” that provides assurance that our member is qualified to minister in this specialized ministry in the name of the church. His (or the religious superior’s, in the case of religious) endorsement acknowledges the NACC process and affirms that this person is “in good standing” and has the “disposition and character” to serve. In most cases he relies on the recommendation of the person’s pastor or a priest in active ministry, and, hopefully more often the case, will personally meet with our member to get to know him/her whenever possible.

The NACC’s connections to the Church are manifold. These include: the approval of our Qualifications and Competencies by the USCCB Subcommittee on Certification of Ecclesial Ministry and Service; the presence of Bishop Donald Hying as our USCCB Episcopal liaison; our Episcopal Advisory Council that meets annually with Bishop Hying and me at the November USCCB Assembly; our
regular communication to all the bishops through Vision; our annual World Day of the Sick letter; the endorsement by the local ordinary or religious community leader of all our board; certified chaplains; and our invitation to the local ordinary or his representative to our NACC national conferences.

We continue to build those connections to our faith body. Some local ordinaries or their representatives meet with groups of NACC members. It is also heartening and affirming when we receive from a bishop, along with an endorsement letter, a note of appreciation for this member’s ministry and of thanks to the NACC for its role in advancing this ecclesial ministry.

How can you strengthen your own connection to the Church and its leaders? I suggest you write to and/or make an appointment with your bishop or his delegate to introduce yourself and share your ministry. Several of you who live in a diocese could make a group appointment, even for 15 minutes, to meet with your bishop, introduce yourselves and where you minister, and let him know the blessings of your ministry. What about sending a card and letter to him during Pastoral Care Week with a message about your ministry?

As you might know, the new Spiritual Care Association does not include endorsement by a religious body as essential to board certification. As the SCA rationale explains, “This endorsement is not an evidence-based indicator of the person’s competency as a chaplain. Faith group endorsement is a relationship between a chaplain and his or her religious/spiritual/existential community. It is largely a Christian structure that is not practiced by most non-Christian groups.” (spiritualcareassociation.org/docs/certification/sca_rationale_for_evidence_based_credentialing_and_certification_standards.pdf)

However, our other chaplaincy Strategic Partners — ACPE, APC, CASC, and NAJC — remain committed to the qualification that endorsement of one’s faith body (as a formal expression of one’s spirituality) remains essential to the chaplaincy profession.

What I have heard from our Episcopal Advisory Council is that your ministry and the mission of NACC are valuable and important to the mission of the church. Let us continue “the healing ministry of Jesus in the name of the church.”

Blessings on your ministry!
How has the certification procedure changed?

By Ramona Zeb and Jeanine Annunziato

The NACC Standards Commission and Certification Commission have renamed the NACC Standards for Certification. We now know them as the NACC Qualifications and Competencies for Certification and Renewal of Certification of Chaplains, in alignment with the other cognate group members who revised the 2004 Common Standards.

In conjunction with the change in name, some changes were also made to the Common Competencies. To help our members navigate the changes, the Certification Commission and NACC office staff revised the entire Certification Procedures Manual. The updated version is available on the NACC website, and the significant changes are highlighted in yellow (www.nacc.org/certification/nacc-certification-competencies-and-procedures/important-background-nacc-certification-competencies-procedures/).

Initial Chaplain Certification: Part One

In several cases, the phrasing and word choice were edited for additional clarity for the applicant. This led to the updating of the certification application form and the creation of several tools to help applicants prepare their application binders. These changes are also intended to help interview teams evaluate each applicant. All applicants must adhere to the new qualifications and competencies and procedures.

The following are some updates and new tools:

- The verbatim is now called a Spiritual Care Encounter, and we have made an instructional cover sheet as a tool.
- Previously, the applicant had to submit student and supervisor evaluations for all four units of CPE completed. We now require only the student and supervisor final evaluations, as well as one student evaluation of the applicant’s choosing in addition to the supervisor evaluation of the same unit. (The applicant is still required to have four completed units of CPE from an accredited institution.)
The Narrative Statement is no longer a single document with a 10-page limit. It has been divided into three separate documents as follows:

- The Narrative Statement I addresses the NACC-specific competencies. There is a writing guide and template to assist the applicant in writing to these competencies.
- The Narrative Statement II addresses the common competencies, and a separate writing guide is available for them.
- The Integrative Theological essay addresses ITP2.1. This competency is more complex and involved, so it has its own instruction sheet.

Applicants often had difficulty meeting the competency related to the Ethical and Religious Directives. Therefore, we have created an e-learning module and post-test, which any current member of NACC can take. The page that contains the link is located at www.nacc.org/certification/board-certified-chaplain/initial-certification-materials. (This page also contains all of our other new procedures and tools.)

Chaplain Renewal of Certification

These updates were designed to incorporate the new competency language and references for NACC members renewing their certification. Changes include:

- “Standard” was changed to “Competency.”
- The Standard Categories were edited to match the updated Categories of Competency: integration of theory and practice, professional identity and conduct, professional practice skills, and organizational leadership.
- We have clarified the expectation that the pastor/priest letter of recommendation for lay chaplains be sent directly to the NACC office.
- Service to the NACC (of an educational value) can be counted for up to 15 hours per year and is to be coded on an applicant’s education report form using “V” in the key column.
- Additional methods for completing a peer review meeting were provided: telephone or voice over internet protocols, e.g. Skype.
• We have clarified reporting activities at which the chaplain recorded time both as a presenter and an attendee.
• Direction were provided on how to report activities that provided updating across multiple categories of competency.
• Total number of hours that may be recorded for retreat attendance is 20 hours per year.
• Information was added relative to the Retired Certified member options for maintaining certification in retirement


With constant review, attention to detail, and questions from members, the NACC Certification Commission hopes that these changes will bring clarity to the process and be more user-friendly to our members.

For questions or comments, please contact the NACC National Office:

• Initial certification — Ramona Zeb (rzeb@nacc.org)
• Renewal of certification — Jeanine Annunziato (jannunziato@nacc.org)
Learning to see through the door

“We have what we seek. We don’t have to rush after it. It was there all the time. If we give it time it will make itself known to us.” — Thomas Merton

By Charles W. Sidoti

As a young child, I remember a picture hanging on the wall in my grandfather’s house. It showed Jesus standing outside a door and patiently knocking. This picture is often accompanied by a caption, “Behold, I stand at the door and knock...” (Revelation 3:20). I realized at that time that the closed door represented the door to my life, the door to my heart. I knew it was about letting God in, and yet I did not know how to put the wisdom that the picture represented into practice. I remember thinking to myself even at that young age, “I will be happy to open the door ... but where is the door?”

As an adult, I reflect on words of the 13th-century Islamic theologian Rumi, “Your task is not to seek for love, but merely to seek and find all the barriers within yourself that you have built against it.” It brings me back again to that image of Jesus and the meaning of that closed door. The picture relates directly to Rumi’s statement because it relates to whatever barrier we may place between ourselves and love — and between ourselves and God, for “God is love” (1 John 4:8). The question that I remember asking as a child and that remains relevant today is, “What does it mean to open the door of my heart to God?”

In saying that our task is to remove the barriers that keep us from experiencing love, Rumi is describing the work of the contemplative life, which is to grow in the awareness of God’s presence.

Evidence of God’s presence is within and all around us. One common barrier to our experiencing it is our tendency to become lost in our own imaginations. In our imagined isolation and self-sufficiency, we have learned to see life through the eyes of what the famous Catholic writer Thomas Merton calls the false self. This is the barrier, the door, between us and God. Seeing through the eyes of this false self, we do not realize that the things in our life, the people, the miracle of simply being alive, and the entire created world are the ways in which God comes to us. These “things” are the tangible presence of the living God. We need to die to
the worried, preoccupied false self and learn to see with new eyes. Jesus spoke of this death and rebirth when he said, “Truly, truly, I say to you, unless a grain of wheat falls into the earth and dies, it remains alone; but if it dies, it bears much fruit” (John 12:24).

Removing the barrier of the false self involves spiritual work. It involves the spiritual discipline of prayer and true humility to acknowledge our faults and to seek God’s mercy and forgiveness. It involves asking for God’s help to remove the falseness that stands between us and the realization of God’s love.

Charles W. Sidoti, BCC, is coordinator of spiritual care at South Pointe Hospital, Cleveland Clinic Health System. He is the author of “Living at God’s Speed, Healing in God’s Time,” and “Simple Contemplative Spirituality.”