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Collaboration in the Church: Extending the reach of Catholic pastoral care

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Collaboration across Catholic agencies has come a long way

By David Lichter
Executive Director

This issue of Vision is dedicated to the Church's pastoral care ministry, of which we are all ministers — whether board-certified members or anyone who continues “the healing ministry of Jesus in the name of the Church.” We are so familiar now with that final phrase of our NACC mission statement, are we not?

Over the past three years, we have explored how the NACC can take more leadership in the pastoral care ministry of the Church. When we submitted a grant proposal to the Raskob Foundation for Catholic Activities (www.rfca.org) in 2015, we explained that in the United States, healthcare reform was having an enormous impact on pastoral care, which is not a reimbursable service, and thus often seen as expendable. NACC's board-certified chaplains often were the vital agents in healthcare settings who helped reshape pastoral care services.

However, in the midst of all these changes, the Catholic Church is still living out its mission to provide healing pastoral care for all who are broken and vulnerable, especially the sick, aging, dying, imprisoned, migrant, and refugee. This ministry is provided in a variety of ways and settings, and those Catholic members providing it require different levels of competencies and education/formation. While many Catholic dioceses and organizations have initiated programs in pastoral care, nationally we do not have consistent sets of competencies, nor approaches for training to ensure the highest quality of pastoral care.

We proposed that a collaborative planning process with representatives from key partners would identify:

1. those with the most critical pastoral needs and the settings where they are found;
2. the type of pastoral care needed;
3. the specific levels of competencies to meet those needs;
4. the diverse ministries involved (board-certified, pastoral associates, volunteers, deacons, etc.);
5. the necessary standards and training;
6. the core elements for professional and volunteer formation;
7. an agreed-upon approach to provide training.

Not too ambitious, were we?

We were delighted to receive approval from Raskob in May 2016 and immediately went to work to invite key Catholic ministry groups to study the landscape and to determine how we could collaborate to address the needs.

Our first meeting occurred in October 2016 in Milwaukee. Those gathered identified the settings where pastoral care needs are most critical. They included elder care; home care settings within parishes; migrants, immigrants, and refugees; and criminal justice settings, including the families of those incarcerated.

To identify the pastoral care competencies needed for those serving these populations, the partners reviewed the USCCB National Certification Standards (<http://www.usccb.org/beliefs-and-teachings/how-we-teach/catholic-education/certification/upload/Certification-Handbook-2017.pdf>) within the human, spiritual, intellectual, and pastoral categories. The planning partners further specified pastoral care competencies within each of these categories.

Before the next planning session in May 2017, work groups met to identify further specific pastoral care competencies for those groups. At the meeting, the partners discussed the outcomes from these work groups, endorsed the competencies developed, and agreed upon some next steps. Those include:

1. Creating one set of competencies for the eldercare and diocesan/parish settings to be shared with the USCCB Subcommittee on Certification of Ecclesial Ministry and Service (SCEMS);
2. Developing further and making available leading practices for preparing and supporting those providing pastoral care in diverse settings;
3. Continuing to explore national recognition processes for the diverse formation programs;
4. Working on an organizational plan for ongoing collaboration for providing education, formation, and other services.

A steering group met in person in Milwaukee on Nov. 30, 2017. Key outcomes for that meeting included:

1. Agreement that our NACC 2019 Conference be dedicated to the pastoral care ministry of the Church at University of St. Mary's of the Lake in Mundelein, IL, on May 29-June 2, 2019.
2. Agreement that the NACC stay in the lead with project management, while all partners work on 2018 deliverables and the NACC works on grants.
3. A list of potential funders to assist in supporting next steps.
4. A willingness to endorse in writing the work going forward, so we have documents for the final report to Raskob and for future potential funders.

Since that meeting, the NACC continues to lead this effort by exploring ways to provide networking and support among those with diocesan responsibility for pastoral care, among directors of permanent diaconate formation, and most recently with the formation committee of the Catholic Prison Ministries Coalition to identify and develop the pastoral care formation needed for those in prison settings.

This leadership role in the Church's pastoral care is a main priority of the NACC's 2018-2020 Strategic Plan. The fruit of these partnerships continues to grow, and our collaborative efforts have received strong support from the bishops, both from our NACC Episcopal Advisory Council, as well as the USCCB Subcommittee on Certification of Ecclesial Ministry and Service.

We look forward to getting all of you, our members, more involved in this partnership effort. And we look forward to our 2019 Conference that will devote itself to our common ministry.

Following the call from Communion minister to BCC

By Sharon Schmidt

I was visiting a friend in the hospital when the chaplain came in. John introduced me to Fr. Tom as a friend and a Communion minister from his parish. Almost immediately, Fr. Tom asked me whether I would consider bringing Communion to the patients in the hospital. I had never given any thought to becoming a minister of care, and I told him so.

But within a couple of days, Fr. Tom called to say that a hospital in the area was offering training for ministers of care. I did not need to make a commitment. I should go to the training, continue discerning, and make my decision then.

And so I did. Four Saturdays in May. That was in 2004. It occurred to me during this time that maybe I was being *called* to this ministry and not just by Fr. Tom! I continued to pray and discern.

About a month after I began bringing Communion to the patients at the hospital, I was diagnosed with breast cancer. Surely, I would not be able to fulfill my ministerial commitment while undergoing treatment — or could I? I did. And I didn't miss even one of my scheduled days.

I was working full time, and I usually brought Communion to the patients on weekends. If I happened to meet a chaplain, the chaplain always greeted me and thanked me for being there to minister to the patients. They told me how important it was that I was there. I was continually affirmed. Other affirmations came in the way Mrs. Cook took my hand in hers and wouldn't let go or the joyful tear on Mr. Peters' face as he prayed with me.

My day usually began with a brief stop in the chapel, asking what God would do through me that day. I wanted to leave whatever I was carrying with me at the door of the chapel so I could be present with those I was visiting. Likewise, I would reflect at the end of my time with patients and their families.

It was not long into my volunteering that I began hearing the call to hospital chaplaincy. It seems obvious now, but I had no idea whom to ask how to become a chaplain and where I might find the requirements necessary. Once I decided to act, I did not run into the staff chaplains, or I did not think to ask. I had no idea there was an NACC or an APC, and they did not readily show up in my internet searches at the time. Finally, I found the CPE supervisor at the hospital at which I was volunteering. Not only could he answer my questions, but he encouraged me.

But I needed a master's degree. I didn't even have a bachelor's degree. There would be a lot of school in my future. Four units of CPE. What is CPE? I was working, full time. Our kids were still in school. I did not see any way that this was going to happen. Maybe I was not being called to hospital chaplaincy.

So I continued to work at a job that was taking the life out of me. I continued to be the best wife and mother I could be. I continued to bring Communion to the Catholic patients at the

hospital. And I continued to pray, asking God to be a little clearer. If God was calling me to hospital chaplaincy, God would show me how it would be possible.

Then it happened. My company was looking for volunteers to leave. So, after 36 years at the job I just never left, I left. And I went to school.

I began my coursework in September 2009, graduating with a master of arts in pastoral studies in May 2015. I began my first unit of CPE at the hospital where I had been volunteering in January 2014. I completed a residency in August 2015 and applied for certification with NACC in February 2016, just weeks before I started as full-time staff chaplain.

Hindsight is 20-20. God's call is so clear now. But it wasn't always. Maybe it was because I wasn't listening or because I was too quick to let the roadblocks stop me. I believe that God puts people in our lives to help us when our ears can't — or won't — hear. God gives us good people to remind us of the gifts God has given us and to demonstrate how we might use those gifts to live the Gospel, to accompany us on that journey, and to affirm us.

Since I finished my training, I have mentored some CPE students, and I do some Minister of Care training in my community. I use story-telling throughout the training, and, of course, my call is right at the beginning of the training as I reinforce the call of every person in that room. This is a great forum to encourage folks who are already interested and discerning whether to take the next step.

Telling you this story, here and now, my journey seems a whirlwind. Let me tell you that many times along the way, it seemed this journey would never end. It probably never will.

Sharon Schmidt, BCC, is staff chaplain at Advocate Illinois Masonic Medical Center in Chicago.

Training program lets parishes send out volunteers with confidence

By Deanna V. Sass

Why should a diocese train the volunteer laypersons who visit the sick on behalf of their parishes? Why not let the parish do what it has always done, hosting an evening or a day of training for new lay ministers? After all, isn't it up to each pastor to determine what his parish volunteers need?

Actually, the Diocese of Trenton has found that there are many good reasons to consider a diocesan-based training model.¹ Permit me to give you four: consistency, confidence, competence, and compassion.

Consistency

We have all heard the horror stories involving volunteers, equipped only with their good intentions and about 15 minutes of training, who go forth into the Vineyard of the Lord, starting blazing fires that need to be put out or defended in court. One hospital volunteer thought it might be OK to "hear a patient's confession" rather than to call a priest — after all, "no one would ever know, and it would bring the patient so much comfort."

If a diocese can plan a training program, which include all of the important features that everyone in ministry should know, the result is a level of consistency among the volunteers in pastoral care and other pastoral ministries, which gives the pastor a certain amount of confidence in those he is sending forth from his parish.

Confidence

Confidence comes from the Latin root words for *with faith*. How wonderful a feeling it would be to have faith in those who represent one's parish in the community. Those good folks who complete the 12 workshops in 30 hours in our diocesan Pastoral Care Training Program earn the confidence of their pastors every day in their various volunteer ministry settings.

They are less likely to make one of the mistakes that many untrained volunteers do, such as innocently publishing a prayer request in the parish bulletin without the patient's permission. Our workshops include teaching about HIPAA regulations, ethics for pastoral ministers, boundaries, secular law, canon law, and self-care, all of which contribute to the competence of the lay volunteer.

Competence

Competence generally means particular skills, or a body of knowledge. The Trenton diocesan program, which I developed and now administer, includes lots of both.

Among the specific skills we teach are listening skills, the nuts and bolts of the pastoral visit, as well as leading rituals for laypersons and pastoral care of the sick and dying. We teach specific skills for working with persons from various cultures, for ministry with the disabled, addicts and alcoholics, incarcerated persons, the mentally ill, and the grieving. We teach how to plan a Christian funeral, and what works and what doesn't in peer support groups, such as those

which many parishes offer for the bereaved or for separated and divorced persons. I used to get frequent calls about how to handle difficult persons in support groups. The training program truly pre-empts those kinds of problems. I don't get those calls anymore.

We complement this training by offering knowledge of the Catholic faith. We include in these workshops the Vatican II documents and Scripture, in which our lay ministries, and the call to service in general, are profoundly rooted. We teach the canon laws relevant to ministry, the theology of suffering, the healing mission of Jesus and our participation in it. We give overviews of what the church teaches about end-of-life decisions, healthcare bioethics, and advance directives.

Equipped with these skills and this body of knowledge, our parish volunteers are more likely to sidestep other ministry landmines. One untrained but well-intentioned volunteer, for instance, promised a terminally ill patient that he would not die if he merely completed a novena to his saint of choice. The additional pain that that encounter caused cannot be expressed by mere words. This is why competence involves more than just skills training and knowledge. It requires a person with spiritual maturity, an emotionally healthy person, one who has self-awareness, and who serves his or her fellow parishioners for all the right reasons. It requires both humility and compassion.

Compassion

Compassion comes from the Latin root words for *to feel* and *with*. That is what we in the ministries of care strive to do, to *feel with* the other. To enter the realm of another's pain, without getting lost in it. To tenderly receive our sister's and brother's stories of suffering, with profound respect, recognizing in them the Divine. Supporting the one who suffers in the search for God in the midst of their pain, for glimmers of grace, with which they might construe hope.

To genuinely offer compassion, we must be rooted in a spirituality of ministry, which happens to be another workshop that we offer in our training program. It is a spirituality grounded in humility, which reminds us that we don't have the right to be with persons in the most intimate moments of their lives — we must be invited in. Once there, we must remember that we don't deserve their gratitude, but instead, their forgiveness, for intruding into these sacred spaces in their lives.

I don't mean to imply we've got it all together. But I have learned what comprises a truly comprehensive and effective training program for lay pastoral volunteers. It will produce consistency throughout the parishes of a diocese and result in lay volunteers with a high level of competence, which will give their pastors greater confidence in their service, and will result in genuine compassion to those in need of pastoral care. Now those are four good reasons to consider a diocesan Pastoral Care Training Program.

Deanna V. Sass is director of pastoral care for the Diocese of Trenton, NJ.

¹<https://www.dioceseoftrenton.org/documents/2018/5/Pastoral%20Care%20Training%20Program%202018-2019%202-PAGE-flyer-2.pdf>

Elder ministry training could be bridge to CPE

By Sr. M. Peter Lillian Di Maria

In 2000, the Avila Institute of Gerontology, the educational arm of the Carmelite Sisters for the Aged and Infirm, saw a need to develop a spiritual care program that focused on the geriatric population. The Geriatric Spiritual Care Certificate Program was launched in 2001, and at this writing, more than 100 students have attended. Some are from other religious orders caring for their elders. Others are laypeople working in a geriatric setting. Others want to increase their knowledge and experience with elders. Some might not be working with elders but want to increase their own self awareness of spirituality.

The curriculum is designed to prepare spiritual caregivers ministering to elders, especially those living in long-term care settings, and includes 65 hours of class time on dynamics of spiritual care, theology of suffering, active listening, moral ethics, palliative care, and community networking. Students also participate in 55 hours of clinical experience, which includes observations of long-term pastoral care, resident visits, a group reflection process, theological reflections, a life review, and a final reflection paper.

The curriculum was designed to provide a spiritual framework that stresses the importance of being present to all elders and helps students recognize the unique needs of those who have memory impairment. In fact, the idea of “being” is stressed throughout the program, as those ministering spiritual care are encouraged to recognize the importance of “being” for one another. Forging these relationships allows students to see the differences between care partnering and caregiving, emphasizing the importance of care partnering with elders.

Our GSC Certificate Program also serves as a bridge to a more in-depth study of pastoral care through clinical pastoral education. In addition, the program is an option for those who want to volunteer with elders but are unable to commit to the CPE course.

Though the program offers numerous benefits, one of the greatest challenges is encouraging people to commit to work with elders. This ministry can be complicated and demanding, even though also extremely rewarding. For elders experiencing cognitive decline and memory impairment, it is often a time of great loneliness; thus, there is a great need for someone to be there to provide spiritual comfort. By providing opportunities for people to learn in the classroom and through interactions with elders, students can begin to understand just how important spiritual care is in this chapter of a person’s life.

In 2017, I was asked to be a part of a committee called the Partners in Pastoral Care, which was funded by the Raskob Foundation and facilitated by the NACC. This partnership has been a great blessing to me, as it allowed me to work with others who are answering the education needs of other ministries.

Working with this dedicated committee emphasized the importance of sharing our programs, best practices, and other aspects of our education because together we can encourage others to become more involved in the different works of Church ministry. Providing people with knowledge about whom they are ministering to spiritually is key to helping people become comfortable with being more active in the many works of the Church.

Spiritual care to elders, especially in long-term care, is different from other forms of spiritual care in that many of the elders we serve are coming to stay with us permanently, making our facilities their new home. Our ministering becomes a long-term relationship. It is a specialized ministry, just as prison ministry or veterans' ministry is. Each ministry is critical, and each ministry needs some common preparation. But each also requires some unique preparation.

I brought the Partners in Pastoral Care Committee discussions back to the GSC faculty, to review our content. We determined that the material was aligned with pastoral care competencies, which acknowledged our hope of being a bridge or introduction to CPE. Together, we saw areas of alignment with the pastoral competencies and made specific suggestions for the competencies for elder ministry. These suggestions were more specific to aging issues and long-term care, such as spirituality for memory impairment, ethical issues, palliative care, family concerns, and long-term relationships that form. We also included a cultural diversity module for both those we might minister to in care centers and those who minister with us.

The most important aspect of this ministry is those called to serve in pastoral care must serve with the utmost care and compassion that Jesus has taught us and our faith continues to nurture.

The committee members have shared many ideas and insights into how to provide high-quality programs that strengthen Catholic pastoral care ministries and ways to collaborate our best practices. I continue to take away many important insights regarding all ministries to our brothers and sisters, especially as it relates to each person spiritually. I have learned the great synergy we have in our works and have become acquainted with very talented people who I feel are a wealth of knowledge and show great compassion.

I continue to be grateful to David Lichter and the NACC for bringing us together to work on a very important project of the Church.

Sr. M. Peter Lillian Di Maria, O.Carm., is director of the Avila Institute of Gerontology in Germantown, NY.

Healthcare Chaplaincy and Prison Chaplaincy: Two Sides of the Same Coin

By Dale Recinella

Jesus' poignant description of the judgment of the nations (Matthew 25:31-46) shows a great deal in common between ministry to the sick and ministry to those who have fallen outside the law. His rebuke, "For I was ... ill and in prison, and you did not care for me," bundles these two deep human needs. The shocked response of the obedient likewise places together the needs of the infirm and of the incarcerated: "When did we see you ill or in prison and visit you?"

My wife, Susan, and I hadn't thought of this divinely affirmed symmetry in mission when we first stepped into formal volunteer ministry. It was the late 1980s, and AIDS was ravaging the homeless in our hometown of Tallahassee, FL. After experiencing a profound Christ Renews His Parish weekend at our church, we felt moved to respond to the crisis in the streets. Through our regional AIDS Service Organization, we took state training for this outreach. I trained to be a buddy for hands-on care to the afflicted, and Susan prepared to support their caregivers. That was as far as we could see.

Then, about a year later, we received a phone call from the evangelical chaplain of a men's prison. He had heard about our work in the streets and wanted me to come to his prison to minister to men with AIDS. To my mind, this was an easy "No!" I had never imagined ministry inside a prison or jail and had no intention of doing so. In the confines of my own home, I dared to say that God could not ask this of me.

A few days later I came home to my wife and children assembled around the dinner table, each with their Bible open in front of them — to Matthew 25. In a lengthy — and for me uncomfortable — exchange, my children confronted me with the words of Jesus about ministering to the imprisoned. Ultimately, I relented, consoling myself that probably very few of the inmates would have AIDS.

After completing all the required training and formalities, I showed up for my first day as a pastoral minister to inmates with terminal illness. The line of blue-clad men waiting for an appointment stretched all the way around the chapel, from the front door to the rear gate. I was not pleased and marched straight into the chaplain's office. "How is possible that all these men have terminal illness?" I demanded. He explained that it was not safe to post a notice that I was available just for men with AIDS. That could jeopardize the life of anyone who came for an appointment. So the signs merely stated that I was a Christian volunteer chaplain available to pray and counsel with anyone.

A chapel clerk had been assigned to set the appointments for my one-on-ones. "How many?" I asked curtly.

"About fifty," he said with a smile. "But that's not counting me. I have an appointment, too."

My sarcasm was palpable. "And just what is *your* terminal condition?"

He looked me straight in the eye. "Sin. Sin is my terminal condition. And you will help me with that, right?"

In a very short time, the needs in the prison eclipsed my other activities. For sure there were bedside needs, even to the point of holding men in my arms as they died chained to their bedframe. But the predominant pastoral need, a thousand times with a thousand different nuances, was for healing. Emotional. Spiritual. Healing of memories and of relationships. Our dear friends Francis and Judith MacNutt were an invaluable resource for our training and understanding. They taught us the basics: Listen, love, and pray.

Over the last 30 years, we have experienced front-line pastoral ministry at every level of security and mode of confinement: male, female, state and local, federal, privatized, even ICE. Long-term solitary, prison hospitals, and the death house. The common denominator is always the same: the deep need for healing. Medical and mental health staffs deal with maladies within their specialties. The ordained provide sacramental pastoral care. The rest falls to those of us who are unordained but available, trained, and willing to be present.

The need is massive. Our nation incarcerates a higher percentage of its people than any other country in the world. Almost all of those incarcerated come with families. The victims of the crimes need healing, as do the traumatized loved ones of both victims and offenders. We need armies of well-trained and well-led Catholic laity to shoulder this effort, which ultimately, even in the darkest corners of our prisons and jails, is a burden of joy, love, and hope in the service of God's restorative work. If you feel you might be called to this ministry, check with your local diocese or visit the Catholic Prison Ministries Coalition (www.usccb.org/beliefs-and-teachings/how-we-teach/catholic-education/catholic-prison-ministries-coalition-cpmc.cfm) or Dismas Ministry (dismasministry.org).

As backdrop to this plight of humanity is what my friends the MacNutts call "the Big Healing," the realignment of our systems — in prison ministry, our judicial and corrections systems — to better reflect God's justice. This is captured in the social justice teaching of our Church.

All these needs are manifested in the work of chaplaincy to the sick and infirm, as well as to the incarcerated. Jesus weighed in on this 2,000 years ago. Let us all lock arms and lovingly support and encourage each other in his work.

*Dale S. Recinella is a Catholic correctional chaplain in northern Florida. He has written several books, most recently *When We Visit Jesus in Prison: A Guide for Catholic Ministry* (ACTA Publications, 2016).*

In Houston, more chaplains, more volunteers, more coordination

By Denice S. Foose and Theodore M. Smith

In spring 2018, the Catholic Chaplain Corps of the Archdiocese of Galveston-Houston launched a major initiative to enhance pastoral care ministry to Roman Catholics in settings such as hospitals, long-term healthcare facilities, and residential homes. We hope that the program will later expand to prison ministry and a maritime setting.

It has been a goal of the archdiocese to establish a larger, better coordinated ministry to Catholics beyond the parish setting. The need is self-evident. The diocese has 1.7 million Catholic parishioners within its 10 counties, with 133 resident priests serving 146 parishes. While the numbers document the need, they also point to a vision: recruit, support, and equip Catholic laypersons to augment the ministry of the clergy.

The diocesan program began with hospital ministry because the number of hospitals is vast: 25 within the city of Houston, 84 in Harris County (which encircles Houston), and scores more in the nine-county area.

The starting point is the Texas Medical Center, the world's largest medical complex with six large, acute-care hospitals. Years ago the archdiocese established the Catholic Chaplain Corps to assist outreach by assigning additional priests to the TMC. Unfortunately, the number of priests has dramatically decreased, yet the number of Catholic patients continues to increase, with a staggering 21 percent to 25 percent of TMC patients identified as Catholic.

Upon receiving a grant for the program from the Foundation of Catholic Health Initiatives-St. Luke's Health, the archdiocese implemented a customized administrative structure to address the large TMC hospitals and the smaller regional hospitals. Simultaneously, a three-tier educational system was begun to equip Catholic laity, called pastoral visitors, to serve in those settings.

Administrative Structures and New Positions

To provide administrative oversight to large hospitals, a full-time position was created, called a lay chaplain. This is a diocesan-funded position, accountable to judicatory's Human Resources Department, but the office is located in the hospital chaplain's suite.

Imperative to the program is the professional training of the lay chaplain, requiring a minimum of two units of CPE. In the past six months, we have successfully installed two lay chaplains at two TMC hospitals, and plans are now being finalized to appoint a third. Their job description includes:

- Identify Catholic patients on the daily census.
- Establish collegial relationships with clinical staff to foster integrated service.
- Coordinate the ministry of pastoral visitors (trained Catholic lay persons) to these patients.
- Conduct follow-up visits to patients not seen by the pastoral visitors.
- Triage requests for Catholic ministry, determining when a priest is warranted. This 24/7 service is especially helpful to on-call CPE students.

A different approach was designed for the suburban areas. Focusing on one specific region, we agreed with three large parishes to create a lay coordinator position with administrative responsibility for ministry to parishioners in hospitals and nursing homes, plus those who are homebound. The position is funded by these churches. The lay coordinator has been serving in this capacity for the past few months and meets regularly with pastoral visitors from these congregations and with the respective hospital chaplains.

Educational Systems

To enhance the ministry of the pastoral visitors, a three-tier educational system was created. More than 200 students matriculated through the spring courses, and we anticipate a similar number for the fall. The following summaries provide an overview of the courses:

- *Module One* – a 12-hour program designed to introduce the pastoral care basics, including empathic listening, pastoral identity, intercessory prayer, and scripture. A three-person faculty leads this program.
- *Module Two* – a 30-hour, 12-week series that addresses topics such as grief theory, death and dying, coping with physical pain, palliative care, Hispanic-American Catholic spirituality, and the ERDs. Writing assignments include verbatim and weekly reflective papers.
- *Certificate Course* – a collaborative two-year program with St. Mary’s Seminary faculty, consisting of eight-week sessions. St. Mary’s professors provide lectures on many standard seminary topics, while program faculty leads supplemental pastoral seminars. The course is designed to increase the participants’ theological and biblical knowledge and help integrate those intellectual gains with their clinical ministry.

Success and Challenge

In many ways, the initiative has gone remarkably well. More Catholic hospital patients are being seen by Catholic representatives, more pastoral visitors are being recruited and trained, and sacramental requests have been expedited. In addition, communication between assigned priests and chaplaincy departments has improved.

Administrative demands have represented the biggest challenge, including attention to organizational detail and alertness to differing institutional practices. Thankfully, through the experience of the past several months, an effective process has emerged, which bodes well for the continued expansion of the program.

The newly crafted competencies have been and will continue to be helpful in designing the educational programs. Every competency in each category has been studied and paired with the most appropriate course. The response to the educational programs has been quite encouraging and portends a robust diocesan program of education and ministry.

Denice S. Foose, BCC, MBA, is associate director of the Catholic Chaplain Corps of the Archdiocese. Theodore M. Smith, D.Min. BCC, recently retired as director of mission integration at Baylor St. Luke's Medical Center in Houston.

Volunteers in Diocese of Dallas get greater opportunities

By Charlie Stump

The Catholic Diocese of Dallas has experienced rapid growth since 2000, from around 500,000 to 1.3 million Catholics within 70 parishes. Hospitals have grown as well, but the last remaining Catholic hospital was sold in 2005. Parish pastors have only enough time to provide sacramental care of anointing of the sick and reconciliation to hospitals within their parish boundaries. With the focus on shorter stays in the hospital, day surgery, rehab centers, outpatient care, assisted living, memory care facilities, home health care, and hospice care, it was time to develop a new model of care.

In recent years, the Diocese of Dallas has increased the number of Catholic chaplains that it employs for hospital work to two priests, three deacons, and two religious. We have also seen more secular hospitals employing Catholic board-certified chaplains. Our two priests cover five hospitals, providing sacramental care, including Sunday Mass in four hospitals, while the deacons and religious provide pastoral care for Catholic patients. But now we are looking outside the hospital walls to assist the parishes in training volunteer ministers and parish-employed ministers of pastoral care.

The vision of the diocese has three levels of pastoral care ministers, beginning with the parish volunteer who has been installed as a Communion minister by his/her pastor. This lay minister completes a 21-hour training program and is commissioned to serve in hospitals, prisons, and ministry to the sick and homebound of their specific parish community.

We hope that many of these volunteers will continue to listen to the call of Jesus and pursue the next, more advanced level of pastoral care ministry. This level of ministry would complete the Certificate in Pastoral Ministry program offered by the University of Dallas Neuhoff School of Ministry. This certificate includes 12 core courses and six elective courses. Courses are typically offered over a five-week period, in two-hour sessions, at a number of sites throughout the diocese.

After completing this coursework and receiving the Certificate in Pastoral Ministry, the minister would then complete at least two units of hospital CPE before being endorsed by the diocese for a paid position in a parish as a pastoral minister of care. The job description for this position would be developed by the parish to include supervision and continued training of the first-level volunteer ministers of care. In addition, this minister would develop a parish relationship with the medical and continued care facilities within the parish boundaries.

This parish role would also be available to deacons who have completed two units of CPE. Recently ordained deacons might receive a dual assignment, one of which would be hospital or prison ministry. A parish with a large roster of volunteer ministers serving a community hospital and caring for the homebound and local assisted living facilities would be directed by an Endorsed Minister of Care who works with the pastor to make sure the parishioners receive necessary pastoral ministry and sacramental care.

The third level of pastoral care is board-certified chaplains employed by the diocese to provide hospital pastoral care. Also included in this model of pastoral care is a deanery chaplain, who is assigned to the number of parishes within the diocese's deanery system. This chaplain will serve as a resource to the pastors and the endorsed ministers of care.

The parish pastor generally has only enough time to be a sacramental minister and an administrator of his church without attempting to provide daily pastoral care. With the help of a deanery chaplain and an endorsed minister of care, the pastor has the additional resources that he needs to know which patients need sacramental care and is comforted by knowing that his parishioners are getting the pastoral care they need.

The Diocese of Dallas is in the process of implementing the program described here. One of the current Catholic hospital chaplains is being reassigned as a deanery chaplain for one of the northern deaneries in the Diocese of Dallas. He will coordinate the existing parish pastoral ministers, provide training for the volunteer ministers of care, and coordinate with the pastors to meet the sacramental needs of patients in healthcare facilities. The deanery chaplain will be the catalyst to implement the parish pastoral care program. As laypeople move through the various steps of the program, we will be able to refine the program to meet the needs of the various parishes.

Pope Francis has challenged us, clergy and lay people, to continue the mission of Jesus. By our baptism we are empowered to care for one another in the Body of Christ. In order to accomplish this edict, we have to rethink and establish new ways of caring for the pastoral needs of Catholics in all settings.

Deacon Charlie Stump, MS, MPM, is director of pastoral services for the Catholic Diocese of Dallas.

Support of pastoral care could follow model for parish ministry

By Harry Dudley

As staff to the USCCB Subcommittee on Certification for Ecclesial Ministry and Service, I helped the bishops approve standards and procedures for certification in specialized leadership positions. We have developed standards and procedures for parish leadership positions, as well as complementary standards for many parish volunteers. An alliance for the certification of lay ecclesial ministers (www.lemcertification.org) was formed to promote this work for parish-related ministries such as directors of religious education, youth ministers, and pastoral associates. The professional associations that formed this alliance now have common and specialized standards for these parish roles.

In the course of this work, I have become acutely aware of the need for a similar alliance for those who do pastoral care outside the parish, such as in facilities for migrants and refugees, prisons, elder care facilities, etc. I am writing to affirm the importance of the current planning initiative of the NACC, which has led beyond its traditional realm of hospital chaplaincy.

As we completed the initial phase of the project, it became more evident that this collaboration is critically needed. Why? The landscape of pastoral care has been dramatically changing:

- Decreasing numbers of clergy require greater and more intentional collaboration with the laity so sacramental efforts can be more focused.
- This increasing involvement of the laity highlights the need for standards and competencies to help in forming them.
- Dioceses need help in providing formation for those leaders who help to manage pastoral care beyond the hospital work that NACC has traditionally supported.
- Except for the NACC, there has been a clear lack of sufficient infrastructure to support the necessary training and certification of those Catholics who want to offer pastoral care.

I have come to believe that history could be repeating itself. NACC was first formed because greater consistency was needed for the recruitment, formation, and support of chaplains. The same is true today. Other professional associations have been shrinking in membership and resources, partially because of aging of chaplains and other pastoral care workers who do the work full time.

For instance, the Association of Catholic Correction Chaplains of America had to dissolve itself this year. Their members were either not being replaced or were replaced by generic “activities coordinators” representing no particular tradition. This happened as we have had an incredible growth in the percentage of our citizens in jails and prisons. An army of volunteers is needed, as well as training for them. Due to the Raskob project and the competencies already developed, NACC was asked to be a partner in the newly forming Catholic Prison Ministries Coalition. I believe that what has been done so far offers a critical step in the right direction.

This effort will certainly identify better ways to assist dioceses in supporting and networking those appointed to do pastoral care. Because many who offer pastoral care do ministry in multiple settings, the common standards and competencies as well as the specialized ones will help assure more consistent and contextual formation appropriate for the various settings in which they serve.

The proposed plan to offer online education and virtual platforms will allow remote and home mission dioceses to access high-quality programs. It is clear to me that this partnership, initially funded by the Raskob Foundation, should continue. I have met with the NACC board and personally thanked them for their commitment to lead the partners in this effort. In my work, I gradually became aware of the fact that NACC has had the gold standard for support of certification. I applaud the board's commitment to expand the benefits of this experience.

In supporting the work of the Subcommittee, I have become acutely aware of the need for an alliance like this for those who do pastoral care in other than parish settings. The discussions and cooperative efforts work of the task force have moved us closer to such a reality.

In *Gaudete et Exultate* (#130), Pope Francis says, "How often we are tempted to keep close to the shore! Yet the Lord calls us to put out into the deep and let down our nets (cf. Lk 5:4). He bids us spend our lives in his service. Clinging to him, we are inspired to put all our charisms at the service of others. May we always feel compelled by his love (2 Cor 5:14)."

Therefore, although recently retired, I offered to join the planning committee for the next major phase of this project: a conference at Mundelein, IL, in 2019 to unveil what has been created. It is my own small way of encouraging the NACC to continue in this effort. Thanks to NACC, the work that flows from this planning process will help to improve existing programs and to train the growing number volunteers who have been inspired by Pope Francis to become involved in pastoral care in hospitals, correctional facilities, and elsewhere.

Harry J. Dudley, D.Min., recently retired as assistant director for certification of ecclesial ministry at the USCCB Secretariat of Catholic Education, Subcommittee on Certification for Ecclesial Ministry and Service.

Catholic outreach fits into NACC's strategic plan

By Jim Letourneau

All who believed were together and had all things in common. – Acts 2:44 (NRSV)

This Scripture line describes the characteristics of the early Christian community: being together and sharing resources. In many ways, these are the experiences of the various Catholic pastoral care groups gathering and collaborating for the sake of the Church's ministry and for those we serve. We are working together to share our resources – our experiences, our training, our hopes, and our wisdom – to strengthen the pastoral ministry of the Church.

Why has NACC entered into this collaboration? Our shifting member demographics challenge us to reimagine who we are and what we can become. In 1996, we had 3,548 members. In 2018, that number has declined to 1,993. In that same time frame, we've shifted from 50 percent religious women, 25 percent lay people, and an average age of 60 to 20 percent religious women, 57 percent lay people, and an average age of 64.

Confronted with this reality, the NACC Board discerned our future strategy. We unanimously agreed that the language in our mission and vision statements continued to animate our identity as well as challenge us to incarnate the healing presence of Jesus Christ. So we embraced our mission and vision and didn't change a thing. We noted that nowhere in our mission or vision did we read the words "hospital" or "healthcare," though most of our members minister in these environments. Knowing the radical changes facing healthcare, and the push toward population health rather than just acute care, we knew our chaplains would be challenged to minister on uncharted holy ground.

We believe NACC is still called to "forming life-giving relationships," as our vision statement says, but we wondered whether we needed to shift *with whom* we formed those relationships. We asked our members whether we should continue our collaborations with our strategic partners in spiritual care (ACPE, APC, NAJC, etc.), or whether we should nurture relationships within the Catholic community (National Conference of Veterans Affairs Catholic Chaplains, American Correctional Chaplains Association, National Association for Lay Ministry, etc.). Unanimously, our members told us to pursue partnerships with *both* groups.

The 2018-2020 NACC strategic plan addresses the importance of these relationships. Our first strategy continues to build on the ministry of professional chaplaincy as we've known and lived it through the years. The second strategy highlights NACC's gift to the Church, as well as the gifts in our mutual relationships with other Catholic ministries. These synergies cannot help transforming our association. While the details are not clear yet, there is great enthusiasm and commitment to our common pastoral ministry, to our Catholic communion, and to "people experiencing pain, vulnerability, joy, and hope," as our vision statement says. Please join me in this exciting journey!

Jim Letourneau, BCC, is the chair-elect of the NACC Board of Directors and the director of promoting Catholic identity and mission initiatives at Trinity Health System in Livonia, MI.

Working across ministries earns bishops' appreciation

By Bishop Donald Hying

In December 2015, I submitted an endorsement letter to accompany a grant application by the NACC seeking Raskob Foundation support for a planning activity among several Catholic ministry associations to strengthen the Church's pastoral care ministry. Two years later, I was so pleased to report to Raskob that its \$30,000 planning grant was not only deeply appreciated, but it supported a remarkable collaboration among more than 20 leaders in pastoral care to develop consensus competencies for the ministry and to commit to establish a network of national resources and training for the thousands of men and women who provide pastoral care in diverse settings in the name of the Church.

From the first gathering of these leaders in the fall of 2016, it was clear that such focused attention to pastoral care as a ministry of the Church was unprecedented and comes at a critical time. While the Church so aptly highlighted in *Co-Workers in the Vineyard of the Lord* the vital leadership roles of lay people in parishes and dioceses in the Church, those providing a pastoral care ministry to the most vulnerable, the ill, the aging, the dying, the imprisoned, the refugee in non-parochial settings have received less attention. Training programs and resources vary from diocese to diocese, and no national standards or models have existed.

Now, with the jumpstart provided by this planning process, we have a consensus document on what competencies are required to provide such care; several examples of good programs; and a strong commitment among the partners to continue their work together.

The NACC leadership is convinced that this initiative aligns well with its mission to "continue the healing ministry of Jesus in the name of the Church." The NACC Episcopal Advisory Council also is very supportive of NACC's leadership. We are grateful to all our NACC members who contribute to their own dioceses' pastoral care training of lay, deacons, religious, and priests. Thank you!

Bishop Donald Hying is the bishop of Gary, IN, and the episcopal liaison to the NACC.

What matters at the end of life

By Kevin Cassidy

I walked into the room and introduced myself as the chaplain. The patient's husband was alone, sitting by his wife's bed. He thought that the doctors had asked me to persuade him to make his wife comfortable. "I'm not going to debate with you," he said.

"I don't want to debate either," I replied. "I'm interested in the same thing as you: the care and comfort of your wife."

"Then you can come in."

Gustov and his wife, Maria, had been married for 22 years. Maria, who was only 43 years old, had end-stage pancreatic cancer. The doctors had told Gustov that his wife would die from the disease. "Make her comfortable and let her go peacefully," they recommended. Gustov refused. "You aren't God," he told the doctors. "God will decide if my wife lives or dies. You just do your thing, and let God do his."

Each day, the doctors would come in, examine his wife, and repeat their grim prognosis. It got to the point that Gustov told the doctors that if they didn't have anything positive to say, not to say anything at all. Over the next few days, Maria's condition worsened. This time, the doctors did speak up. "It's just a matter of time," they said. "Let us make her comfortable." Again, Gustov said no. But he did agree to a DNR. "If her heart stops, that means God wants her."

"What's helping you get through this?" I asked.

"My faith," he said. "She's been sick before. And back then, those doctors told me the same thing: She was going to die. But she's always gotten better. So God is not going to abandon her now. That's why I don't want the doctors to stop their medicines or turn off their machines. I want to give God the chance to perform one more miracle."

"What would your wife say?" I asked. "Did you two ever discuss what you would want at the end of life?"

"Never," he said, "because it doesn't matter what we want. All that matters is what God wants."

Two days later, Maria died from a blood clot. In keeping with Gustov's wishes, the staff did not try to revive her. I went to see Gustov. I expected him to be mad at God.

"How can I be mad at God?" he said. "It's not the answer I wanted, certainly. But it's his decision and his alone. And I must accept it."

"Would you like to say a prayer?" I asked.

"No," he said. "I already said my prayers."

He was in a hurry. “I need to start making funeral arrangements,” he said. He shook my hand, said goodbye, and picked up his phone to call the funeral home.

I turned to look at Maria one last time. And I saw a picture of Maria that I hadn’t seen before, a picture someone must have recently brought in and placed on her tray table — a laughing Maria, full of beauty, youth, and life.

And then it hit me: It didn’t matter whether the doctors were correct in their prognosis.

It didn’t matter whether I thought Gustov’s conception of God was theologically flawed.

What mattered for Gustov was his wife — the woman in the bed who once was the woman in the picture — a woman I did not even know.

Gustov was just trying to save her by relying on that one thing that, up until now, helped him make his way in this uncertain, unfair, and often cruel world: his faith.

And I became upset with myself and the doctors for not treating that personal and sacred part of Gustov with more reverence.

I don’t know how I will react when my loved one is in that bed, about to leave me by myself. However I react, I pray that I have a compassionate companion by my side — someone who will not judge me but accept me, understanding that I am just trying to do my best ... during the worst time of my life.

Kevin Cassidy, BCC, is a Chaplain Level III at Loyola University Medical Center, a member of Trinity Health, in Maywood, IL.

If science predicts when you will die, how does that affect your spirit?

By Allison DeLaney

What is a hospice chaplain's scope of practice? I thought I had a clear answer for myself, having spent eight years working in a small, rural, nonprofit hospice house, but then I read an article about a wild invention: artificial intelligence to predict mortality in patients.

The idea was born¹ when Dr. Stephanie Harman, Stanford's founding medical director of palliative care services, partnered with Nigam Shah in the biomedical informatics department. They used electronic health records of 2 million patients to predict mortality in the subsequent three to 12 months. The resulting algorithm has resulted in an all-cause mortality prediction model, which is being piloted by researchers and physicians.

To be clear, they are using statistical data from many different types of illnesses to predict the likelihood that one will die. The argument for it goes like this: We assume that palliative care teams are an important resource near the end of one's life. Too often palliative care recommendations are absent or delayed. If doctors had the help of AI to predict death, then they would be more likely to refer these patients to palliative care. The logic is captivating: earlier intervention, better patient care.

But after learning about this project, I was both shocked and curious. As a hospice chaplain, I have witnessed diverse ways that patients and their families find meaning during health crises and how they come to terms with vulnerability and mortality. How might this affect patients and families? How might it change the relationship between healthcare staff and patients? I now felt compelled to reflect on this type of data, how it is used and interpreted, and what it might mean for my patients and professional practice.

The introduction to the Ethical and Religious Directives provides a healthy foundation: "The dialogue between medical science and Christian faith has for its primary purpose the common good of all human persons. It presupposes that science and faith do not contradict each other. Both are grounded in respect for truth and freedom. As new knowledge and new technologies expand, each person must form a correct conscience based on the moral norms for proper health care." Perhaps the Stanford researchers and hospice chaplains are interested in a common goal: to relieve suffering as we near the end of life. In this case, AI could enhance what physicians are already trying to do: guess when we are going to die. To gain access to the hospice benefit, a doctor must certify that a patient has six months or less to live. Not surprisingly, the accuracy of those predictions differs based on the relationship between the physician and the patient. As the length of the patient-physician relationship increases, so does the probability² that the physician will be overly optimistic about the patient's life expectancy. Would AI help physicians be more aware of their patient's mortality? If Stanford's AI were proved accurate (this is still to be determined), what repercussions would this have for the spiritual care of patients, families, and staff?

I hope this is where we can ask the questions that won't be pondered otherwise. Chaplains have extremely valuable data points about coping with mortality and providing competent palliative and hospice care. The knowledge that one might die sooner than later starts a chain reaction of emotions and questions. Will the knowledge help improve the quality of time I have left? What resources will I have to help me face existential concerns? Feelings of anger, abandonment? Will it spur despair/hopelessness? Grief? Guilt? Will I feel isolated or choose isolation? Will I experience spiritual and/or religious struggle? All these concerns tend to follow the initial prognosis of death.

We know that palliative care is a valuable resource³ that can enhance quality of life precisely because it embraces the constellation of questions that come with mortality and does not separate the knowledge of mortality from its repercussions. My concern around Stanford's mortality prediction algorithm is the way this information could harm patient-provider relationships and access to care. Perhaps these statistics could be used for cost savings to justify withholding treatment to the most vulnerable. I also fear the doctor who trusts the algorithm more than listening to my signs, symptoms, and story. If the computers predict my death, throwing my life off course, and it turns out to be a mistake, no one might be held accountable. The list of fears is long because the weight of knowing that death is near is dangerous — if divorced from compassionate and sensitive communication and trusted relationships.

This technology, used in a moral and ethical context, might do what the Stanford AI team hopes: provide more timely palliative care resources targeted at the people who need it most. Perhaps it will give insurance companies and policymakers the evidence needed to fund more palliative care and further improve access. All this benefit, too, is possible.

Why is this a concern for us chaplains? Because to be silent on technological advances is to promote technological monism, the idea that the most meaningful problems and solutions depend primarily on technology. The answer to human suffering and mortality is not only an accurate prediction of my date of death.

As human beings, consumers of healthcare, people trying to develop systems of care that help us live well until our death, we chaplains must argue for addressing the innate emotional and spiritual needs that arise when we struggle with mortality. I believe it is our professional duty to illuminate the data, qualitative, and quantitative, that arises from our patient-based experience, to evaluate the context in which these statistics will play out.

My hunch is that the more accurately we can predict death, the more our physician and healthcare colleagues will need support in how to "break the bad news" to even more patients. In a time-crunched, resource-limited environment, creative interdisciplinary initiatives are addressing this need for sensitivity training, communication skills, self-reflection, and spiritual awareness. Let us gather the wisdom and lessons learned from our experiences working at the edges of life, illness, and death and make the much-needed case for presence, story, meaning-making. Improved end-of-life care includes good access to quality spiritual care, which is more possible with better chaplain-patient and chaplain-staff ratios. Hopeful initiatives that directly

improve palliative care through building healthcare workers' empathy include the practice of narrative medicine initiated by Dr. Rita Charon of Columbia University and interdisciplinary reflection rounds led by Dr. Christina Puchalski at George Washington Institute for Spirituality and Health.

In the end, technologies such as the Stanford AI algorithm that aspire to predict our probability of dying offer radical new possibilities for approaching palliative and end-of-life care. Aside from "When will I die?" the more compelling question is, "How does this change the quality of support that I receive?" The Stanford researchers acknowledge that their pilot needs to study the effect of AI on physician behavior and the extent to which the resulting care aligns with patient wishes. This is a chaplain's wheelhouse and demands that we engage with strange and new technologies so we can indeed fulfill our professional duty to appropriate spiritual care. Our experience, our data points, are needed if this technology (or any new technology) will benefit rather than hurt patients who are already vulnerable.

Allison DeLaney, BCC, MA, MPH, PT is pediatric and women's health chaplain at Virginia Commonwealth University and is part of the first cohort of chaplains to earn a master's degree in public health through the Transforming Chaplaincy initiative.

Notes

¹ <https://spectrum.ieee.org/the-human-os/biomedical/diagnostics/stanfords-ai-predicts-death-for-better-end-of-life-care>

² <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1070876/>

³ <https://www.liebertpub.com/doi/10.1089/jpm.2009.0142>

For better or for worse, a lot of Richard Rohr

Richard Rohr, *Essential Teachings on Love*, Orbis, 2018. 263 pp. \$22

By Anne M. Windholz

Richard Rohr's *Essential Teachings on Love* is a compilation of thematically arranged excerpts from his writings and talks over the years. Divided into four large sections — "Love as Foundation," "Loving Others," "Loving Self," and "Loving Everything" — the book follows the chronology of Rohr's life. The collection, not surprisingly, addresses major themes of Rohr's teaching: the power of incarnational love; love and suffering as the great spiritual teachers; the spiritually crippling impact of religion's "worthiness" myth; and the relational nature of the Trinitarian God.

He entertains what he calls "alternative orthodoxy," engaging with key but also controversial figures in 20th-century Catholicism — Teilhard de Chardin, Thomas Merton, and Dorothy Day — as well as giants of his own Franciscan tradition: Duns Scotus, Bonaventure, and of course Francis himself. While he maintains an essential — he calls it "conservative" — Catholic identity in revering the real presence in the Eucharist, he also embraces ecumenism and interreligious dialogue in the most small-c catholic sense. Paradox, Rohr notes, is our nature.

For chaplains who understand their vocation as Catholic, Rohr shows how an expansive faith that embraces all peoples and spiritualities can be grounded in Catholic tradition, education, and world view. He readily embraces the wisdom of Judaism, Buddhism, Hinduism, and other world religions. His observations have much to teach those of us serving within often inspiring, always fallible, and sometimes frail human institutions. Rohr's intense compassion for those marginalized in our society — the LGBTQ community, the prisoner, the poor and the voiceless — models an open-hearted acceptance that every chaplain should emulate. His attentive study of Twelve-Step spirituality makes him a valuable resource to chaplains companioning anyone suffering from addiction. Rohr understands that the power of presence is greater than that of words, a lesson we learn early as chaplains.

Of course, Rohr's own work as lecturer, writer, and teacher is all about words — and this book cannot avoid underscoring certain pitfalls in his own practice. His arguments against the "false self" and in favor of the "True Self" sometimes veer dangerously close to the very dualism and labeling that he attacks as destructive. And the book as a whole occasionally slips into an unintentional hagiography that makes Rohr — rather than God — the center. Even Rohr's admission of his weaknesses and mistakes cannot quite eradicate the occasional sense that Rohr needs to become less, so his subject — love *of* God, love *by* God, and love *for* each other — can become more.

But Rohr is a powerful, prolific, and impassioned messenger. His counter-cultural emphasis on vulnerability and mutuality speaks to the heart of chaplaincy. Heeding his closing words, may we be guided as chaplains and disciples of Christ: "Never doubt that it is all about love in the end."

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