

ADVANCING THE INTEGRATION OF SPIRITUAL CARE IN WHOLE PERSON CARE

Caring for the Human Spirit[®] magazine

FALL/ WINTER 2019

**THERAPEUTIC STORYTELLING
UNCOVERING THE
INNER NARRATIVE**

**A HOSPICE CHAPLAIN'S
JOURNEY TO BOARD
CERTIFICATION**

**A HOMECOMING
WORKING AS A
STAFF CHAPLAIN
AT MEMORIAL
SLOAN KETTERING**





Nursing Division of the SPIRITUAL CARE ASSOCIATION

Belong to a supportive professional community that welcomes both novice and seasoned nurses interested in spiritual care

The Nursing Division of SCA welcomes nurses interested in learning and sharing best-practice nursing spiritual care and self-care through education, networking, mentoring, and obtaining a myriad of resources. [Join Us!](#)

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HealthCare Chaplaincy Network™ is a global health care nonprofit organization that offers spiritual-related information and resources, and professional chaplaincy services in hospitals, other health care settings, and online. Our mission is to advance the integration of spiritual care in health care through clinical practice, research and education in order to improve the patient experience and satisfaction, and to help people faced with illness and grief find comfort and meaning—*whoever they are, whatever they believe, wherever they are.* We have been caring for the human spirit since 1961.

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Comments? Suggestions?

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Chaplain Ratios – A Misleading Metric

By **The Rev. George Handzo, BCC, CSSBB**
The Rev. Susan Wintz, BCC

The most common question we are asked by health care chaplains and administrators is some version of “How many chaplains are recommended for X patients?” Usually the question is asked within the context of a certain population of patients—hospice, pediatrics, oncology, long-term care, ICUs, etc. Our short answer to this kind of question is something like, “No one has these current numbers, no one should, and you shouldn’t go by them either.” Now we have the questioner’s attention.

After years of being in health care chaplaincy practice, serving in national leadership within the profession, (this needs a verb like the other phrases (being, focusing, doing) so there is parallel construction—for example, “serving as national leadership”), focusing on quality issues, and doing consulting around the country, we believe using ratios as a core metric for determining chaplaincy staffing was never a good idea, and in the era of value-based care, it has less meaning than ever. That said, all metrics have some value. If you are a 400-bed general hospital with an emergency department and have one chaplain, you are pretty clearly understaffed, but you should not need an industry benchmark to know that.

The problem with ratios, no matter how specific, is that every situation is unique and has unique staffing needs. If you are a hospice chaplain with a 50-patient case load, those cases could live within 10 blocks in Manhattan or in 10 large counties in west Texas. The time needed to see them varies immensely. Does your hospice have good social work staffing, or is the chaplain expected to carry a lot of that load? Is there a bereavement coordinator, or does the chaplain

effectively fill that role as well? In short, the permutations are virtually endless.

Several years ago, there were some published ratios in health care chaplaincy. All of them were dropped long ago because they proved not useful. They held back as many chaplain staffing efforts as they helped. For instance, “50 patients per chaplain” was a common quote that our own chaplaincy experiences showed was not realistic if you covered a large pediatric service on which all of the children had cancer, or a very large neurology/neurosurgery intensive care unit in a level-one trauma center, which were our experiences.

So, how does one determine what comprises an adequate chaplaincy staffing for a given situation? The advent of value-based care can direct us here. Ratios are a volume measure. They are best suited to situations in which the value of the chaplain is based on how much of something (normally patient visits) the chaplain does. However, U.S. health care is now rapidly and irrevocably moving to a value-based economy, where value is determined by how much everyone, including the chaplain, contributes to “value.” How is value determined? Classically, value is what the customer says it is. In this case, that customer is the employer (i.e., the hospital or hospice). We generally say it is the person who signs the checks.

The key to this process is determining how the customer (aka the stakeholders) want the chaplains to contribute value. A good place to start is with the HealthCare Chaplaincy Network Quality Indicators for spiritual care. This document can be an excellent discussion starter for what chaplains can contribute. From

this list, an institution can decide what indicators contribute most to their situation. The decision should be made with all the important stakeholders participating. If the venue is a team, such as a palliative care or intensive care unit team, the stakeholders would include at least the team leadership and institutional administration. In other cases, the decision might be made by upper-level institutional administration, but with chaplain input. The stakeholders will vary, but it’s important not to leave any of them out.

Once the decision has been made about what outcomes the chaplain is expected to contribute to (e.g., patient satisfaction, staff burnout, meeting spiritual needs at the end of life to reduce cost, etc.), the next questions are: What staffing has to be in place to deliver these outcomes? What processes, such as spiritual screening, have to be in place? How will you know how you are doing on delivery of these outcomes? These questions essentially form a feedback loop. If the metrics for measuring the outcomes are showing a significant gap between current state and the goal, staffing may need to be adjusted, and/or a process may not be working the way it was hoped. Then, more data is collected, and more adjustments are made as indicated. And so on.

Clearly, part of the lesson here is that this is an ongoing process which never ends. It’s also a process that involves a team of stakeholders with the chaplain in the lead. Finally, this is not about ratios. It is about positioning chaplaincy to add maximum value to the institutions and the patients they serve.



First Responder Chaplain Division of the SPIRITUAL CARE ASSOCIATION

Are you a fire, police, or first response chaplain? Are you a volunteer or community leader looking for more training in spiritual care for crisis, trauma, and disaster first response?

Then the First Responder Chaplain Division of the Spiritual Care Association is perfect for you!

The First Responder Chaplain Division of SCA focuses on the spiritual dimension of professional first response practice including professional chaplains, volunteers, community leaders, and all members of a first response team.

Join Us!

EARN YOUR CRISIS, TRAUMA, AND FIRST RESPONSE CERTIFICATE

The Crisis, Trauma, and First Response Certificate Course for Chaplains provides the basic and fundamental skills and knowledge needed in order to provide chaplaincy spiritual care to those people who have been impacted by an emergency, crisis, trauma, or disaster. Upon completion of this online, self-guided course, you will earn the Crisis, Trauma, and First Response Certificate.

DOWNLOAD THE FIRST RESPONDER CHAPLAINCY TRAINING MANUAL

The SCA's comprehensive training manual is a resource for those who currently provide spiritual care as members of a first response team, or who desire to begin a chaplaincy component within their team. Drawing on national expertise in the fields of first response, emergency, and disaster chaplaincy and volunteer management, this manual addresses key areas such as diverse and vulnerable populations, communication skills, psychological first aid, and more.

Learn More at www.spiritualcareassociation.org/first-responder-chaplains



The Path to Excellence

By Rev. Raymond G. Coffman BCC

It was a typical sunny autumn morning in the South. However, the meeting I was about to attend was anything but typical for my 20-year tenure as a hospital chaplain. I was prepared to join my chaplain colleagues for our monthly meeting, nice enough but not too exciting. Before we started, a gentle knock on the door preceded the appearance of our hospital's director of foundation giving and one of my former patients, smiling brightly from ear to ear. It was Keith. I was surprised.

Keith was a patient I'd met during his stay in our CCU months earlier. During his 40-day admission to our suburban Atlanta hospital, he joked about being on every unit except Labor and Delivery. At first, it was his partner and twin sister who were the recipients of spiritual care. As Keith got stronger, we became friends. Our visits were never long or overly religious, but they were often very significant. On Thursday afternoons I always made sure Linda, our music practitioner, stopped by with her harp for some music therapy. He loved it!

Keith left our hospital from the Inpatient Rehab Unit to heal at home and plan an important trip—one he had dreamed of during his stay and discussed with me. Going on this trip was a goal he focused on during his stay to motivate himself to heal. It was a trip to Asia and Europe, and a flight that would take him around the world. The dream became a reality! Once he returned, we had met for lunch at his home. I fondly picture him in his souvenir baggy lounge pants embroidered with Thai elephants. While watching

a PowerPoint presentation of his photography, I celebrated with Keith and his partner his healing and the accomplishment of his dream vacation.

Now, what was Keith doing here at our staff meeting? Keith announced that to show his appreciation for the spiritual care he received, he was donating funds designated for education and training. Somehow knowing that out-of-state conferences were not often in our budget, this was his way to express his appreciation. I was thrilled!

Months later, I left the sunny South to attend my first HCCN Annual Conference in snowy and windy Chicago. It was there that I learned of the HCCN Excellence in Spiritual Care Award. As a long-time chaplain and manager, I knew we were doing many things well. However, I also wanted an expert assessment of our work, so that we could make improvements in areas that would assist us in meeting Joint Commission standards for spiritual care.

Our hospital president and administration supported our proposal. We began our journey of gathering data, accessing our work, and showcasing our strengths. Once into the assessment, we realized this was going to be a 6-8-month process. After a lot of teamwork from our staff, we were ready to submit our heavy loose-leaf binder filled with our work. Our consultant, Brian Hughes, was a steady presence and guide along the way. After several edits, we heard the news. In March 2018 our hospital was awarded the Excellence

in Spiritual Care Award and was the first in the state of Georgia to receive this honor.

I remember Brian saying, "Enjoy the publicity, your team deserves it!" Our hospital administration and our team members were thrilled that we were not only the first in our 11-hospital system, but the first in our state to receive the Excellence Award. We were recognized by our company CEO and COO, and highlighted in hospital and community media. Our hospital president & CEO mentions it to this day when speaking in the community and has developed a greater awareness of our interdisciplinary role in healthcare. He/she often starts leadership meetings with a reflection from Spiritual Health. Our staff grew from 1.5 chaplains to two full-time chaplains. We went from one board-certified chaplain to now two. Our department name changed from Pastoral Care to Spiritual Health to better define our inclusiveness. We are in the process of building a new centrally located chapel and office suite with funds donated by staff to replace an old, outdated space. All of these changes connect back to a greater awareness of the chaplains' role and function in modern-day healthcare.

We learned too that we had areas that needed to be developed if we wanted to strive for higher standards of improvement, opportunity and growth in providing 21st century spiritual care. We began integrating various assessment tools, including a spiritual history for the non-religious. We have used a variety of educational opportunities

in staff support to teach staff how to screen for spiritual distress, and we have provided in-service education on compassion fatigue. Encouraged to be cultural brokers, we implemented the first traditional Ramadan Iftar, with an emphasis on patient care for Muslim individuals. This fall we will offer a Diwali Celebration for our Hindu, Sikh, Jain and Buddhist staff.

What started as a donation from my patient Keith to offer opportunities for personal and professional growth has inspired our whole chaplaincy team and hospital to strive to provide world-class spiritual care. While working on the application, I was asked by Keith to officiate an intimate New Year's Eve wedding service at his home overlooking the sparking Atlanta skyline. What a unique evening for a chaplain: to become a special part of a former patient's life after an encounter that started in a CCU. A few months later, Keith struggled again with a critical illness. Sadly, Keith passed away. At his memorial service, I shared what a great gift he had given to me and our department. I will always be grateful to him for his act of kindness that initiated change, growth and recognition all for the good! However, even in his death he continues to surprise me as he did that sunny autumn morning; a generous memorial gift from his family to our chapel renovation will constantly remind us of a man whose kindness gave our department a vision for excellence in all we do and how we deliver care in this 21st century.

Rev. Raymond G. Coffman is the Manager of Spiritual Health at WellStar Cobb Hospital in suburban Atlanta, Georgia. Raymond is board certified with the Association of Professional Chaplains. Raymond just celebrated 25 years of chaplaincy with the largest healthcare system in Georgia, and he loves ministering to patients, their loved ones, and his hospital staff.



RESOURCES & EDUCATION

The Catalog for All Things Spiritual Care

HealthCare Chaplaincy Network and the Spiritual Care Association are the leaders in research, education and clinical care. Since 1961, we have been working to make spiritual care a priority and have created educational opportunities, programs and services to assist spiritual care providers and institutions of a variety of fields the guidance and formation that will meet their specific needs.

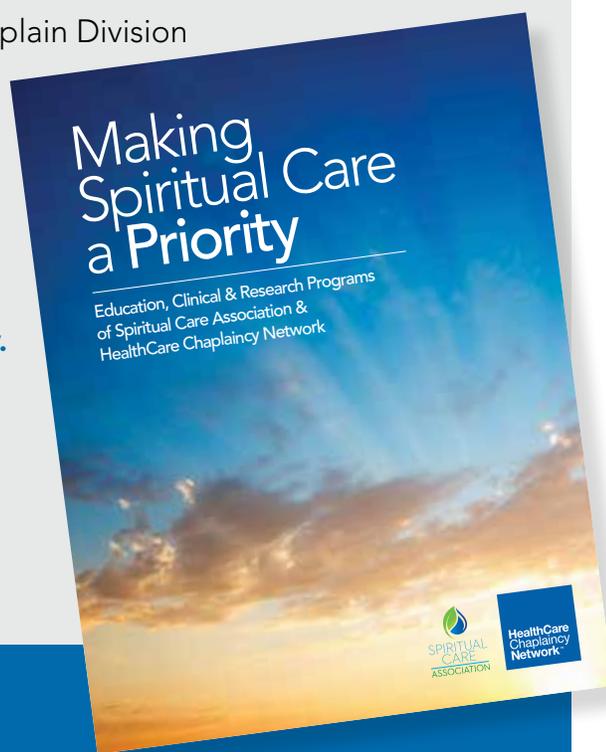
Want to know more?

You'll find information on SCA's

- Annual Caring for the Human Spirit Conference
- University of Theology and Spirituality
- Learning Center
- Health Care Chaplain Division
- Nursing Division
- First Responder Chaplain Division
- Hospice Division

And more

Our comprehensive Catalog on Spiritual Care is available by visiting healthcarechaplancy.org/docs/priority/catalog.pdf





Hospice Division of the

SPIRITUAL CARE ASSOCIATION

The SCA's new Hospice Division focuses on the spiritual dimension of professional practice including professional chaplains whose specialization is in this setting, as well as community leaders serving as chaplains or spiritual care generalists, and all members of a hospice team.

It supports the advancement of the spiritual care component of hospice services as an essential aspect of high-quality whole person care for all including the professional providing the care.

Why Join?

If you are a

- Professional board certified (BCC, APBCC, APBCC-HPC) or credentialed chaplain (CC) or a chaplain candidate who wants a specialization certification in hospice and palliative care
- A community leader providing spiritual care within a hospice organization who wants a certificate demonstrating your knowledge and skill
- A member of a hospice team interested in incorporating spiritual care into your practice

The Hospice Division of the Spiritual Care Association is perfect for you.

Palliative Care Courses

Delivering quality spiritual care to palliative care patients requires both the chaplain as the specialist and involvement by the other members of the interdisciplinary team as spiritual care generalists. The hundreds of health care professionals who have completed these courses such as Fundamentals of Spiritual Care in Palliative Care and Advanced Practice Spiritual Care in Palliative Care say that as a result they have significantly enhanced their knowledge and skills to deliver spiritual care in palliative care settings.

Hospice Chaplaincy Certificate

This online, self-guided course is designed for those interested in the specialized work as a chaplain within a hospice team. Its purpose is to empower learners with the basic skills and knowledge needed in order to provide care to persons and families who are admitted to hospice as well as to contribute effectively as a member of the hospice interdisciplinary team.

Chaplaincy Management Training Program

Leading a successful chaplaincy department is filled with opportunities and challenges. Many directors have requested tools and training to provide successful leadership to support their staff and provide quality spiritual care to patients, family, and staff. This is a 4-month program that is ideal for current or aspiring directors of chaplaincy/spiritual care departments of any size.

Learn more about SCA's Hospice Division at
<https://spiritualcareassociation.org/hospice>

HIGHLIGHTS

To view these summaries online, visit www.healthcarechaplancy.org/conference.html

KEYNOTE SPEAKER / Monday, May 20, 2019

Advancing Spiritual Care through Palliative Care Globally: Opportunities and Challenges



“Palliative care is not end of life care; it is quality care for anyone with a serious illness.”

Dr. Kathleen Foley, M.D.

Attending Neurologist Emeritus
Memorial Sloan Kettering Cancer Center

Role of spirituality in the United Nations, where the World Health Organization sits. UN NGO Committee on Spirituality Values, and Global Concerns Evolving Mission Statement puts spirituality at the center.

2002 WHO Definition of Palliative Care: **“Palliative care is an approach which improves quality of life of patients and their families facing life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial, and spiritual.”**

Palliative Care as a public health issue affects all people, need for better information on end-of-life care, potential to prevent suffering, potential to prevent disease.

2014 WHO resolution on access to palliative care said that PC was an ethical issue and central to relief of suffering: "Strengthening of palliative care as a component of integrated treatment within the continuum of care." All countries to strengthen the provision of palliative care including addressing spiritual issues. <https://www.who.int/ncds/management/palliative-care/en/>

Part of Human Rights Watch – reports available online. <https://www.hrw.org/sitesearch/palliative>

New Initiatives in Global Palliative Care: Major International Reports

Religions of the World Declarations on Palliative Care for Children:

- Children
<http://religionsworldcharter.maruzza.org/about/>

The PAL-LIFE Project supported by Pope Francis and the Pontifical Academy of Life

- <http://www.academyforlife.va/content/dam/pav/documents/Cochin%204.pdf>

New Definition of Palliative Care by IAHP

- <https://hospicecare.com/what-we-do/projects/consensus-based-definition-of-palliative-care/definition/>

These reports helped sharpen understanding of the global need (and the need of individual countries) for palliative care, its essential elements, the number of people suffering, the days of suffering, and the needs of children. Intervention: Essential Package includes medicine, medical equipment, and human resources.

WHO and committee are very supportive of spiritual care. The difficulty in human resources was the provision of spiritual care: how to think about what spiritual care is, who providers are, and costs. What is the minimum package for spiritual care? Spiritual care specialists need to contribute to this work.

Opportunities to advance spiritual care in healthcare

- Spiritual concerns are a component of the WHO definition and are included in the proposed WHO resolution, with strong support for it as central to palliative care
- Increasing international consensus on a definition of spiritual care
- Taxonomy of what chaplains do

Challenges to advance spiritual care in healthcare

- Palliative care is a new field of medicine with a small workforce
- Prevalent concerns that spirituality is not the domain of healthcare providers
- Increasing secularism that disparages spirituality discourse
- Lack of robust models to assess service costs for universal health care inclusion

With professionalism of spiritual care comes the integration and plan to cover costs. Identify the time, outcomes, and data. How to think about financial model – how to pay for chaplaincy/spiritual care; what are the numbers being used by institutions and plan for provision of spiritual care? How can a model be sustained?



Over the two years that the Spiritual Care Association (SCA) has been certifying health care chaplains, we have made numerous attempts to help chaplains and health care administrators understand the major differences between the SCA system and others with some success, but there is continuing misunderstanding on some major points.

The basic distinction between the SCA process and others in the field is that the traditional chaplain certification process focuses on how much training a candidate has and who that chaplain trained with, followed by a highly subjective and unstandardized review. The SCA process, while not unmindful of training, focuses on whether the candidate can demonstrate command of core knowledge linked to evidence-based spiritual care quality measures and direct observation of the chaplain's interaction with a simulated patient. In other words, can the chaplain deliver quality spiritual care?

The core knowledge test is the only one of its kind in the industry. Candidates for SCA certification are the only ones in the industry who have had to demonstrate knowledge of the major content areas related to chaplaincy practice. This test is completely objective and periodically updated to reflect new knowledge and research in the field.

In a traditional chaplaincy certification process, clinical competence is evaluated by the chaplain's self-report of a clinical encounter presented in writing and augmented by discussion with several peers. This self-report is generally incomplete, subject to the chaplain's memory of what actually happened, and cannot show the reviewers the non-verbals including tone of voice and pastoral presence that everyone agrees are central to the chaplain encounter. Often the encounter is with a patient the chaplain knows well and thus knows how to approach successfully. In short, the process tests what the chaplain thinks they did or what they would like to have done. In the SCA process, the chaplain engages in an encounter with a live, simulated patient. The chaplain has only a brief referral shown to them about a minute before the encounter as a preparation. Thus the chaplain's assessment and relationship building skills are fully tested along with their non-verbal skills such as eye contact, pace and tone of voice. Within 30 minutes of the conclusion of the visit, the chaplain must submit a written chart note, thus demonstrating their writing ability in the context of the job-related task of communicating with the clinical team. In short, the process evaluates what the chaplain actually does do under conditions that closely approximate their actual work situation.

We believe that these innovations merit inclusion of SCA certification as an allowable option for all health care chaplaincy positions. It is important to note that SCA has offered both of these innovations to the other chaplaincy certifying bodies. We continue in discussion with several of them on these topics but most of the major associations have declined this offer. We believe these methods are significant improvements on existing processes and would welcome other that want to adapt or adopt them.

The Rev. George Handzo, BCC, CSSBB
Director, Health Services Research & Quality
HealthCare Chaplaincy Network



SPIRITUAL CARE ASSOCIATION

The interdisciplinary, international professional membership association for spiritual care providers that has created the first comprehensive evidence-based model to define, deliver, train and test for the provision of high-quality spiritual/chaplaincy care

WELCOMING as members all individuals and organizations committed to the delivery of optimal spiritual care as a vital component of whole-person care and the overall patient experience

EDUCATING chaplains, physicians, nurses, social workers, other health care professionals, and clergy via a robust Learning Center

ENGAGING all interdisciplinary team members, recognizing that the delivery of spiritual care requires both generalists and specialists

OFFERING new pathways for chaplain credentialing and board certification to ensure demonstration of clinical competencies

ADVOCATING to advance the integration of spiritual care in health care around the world

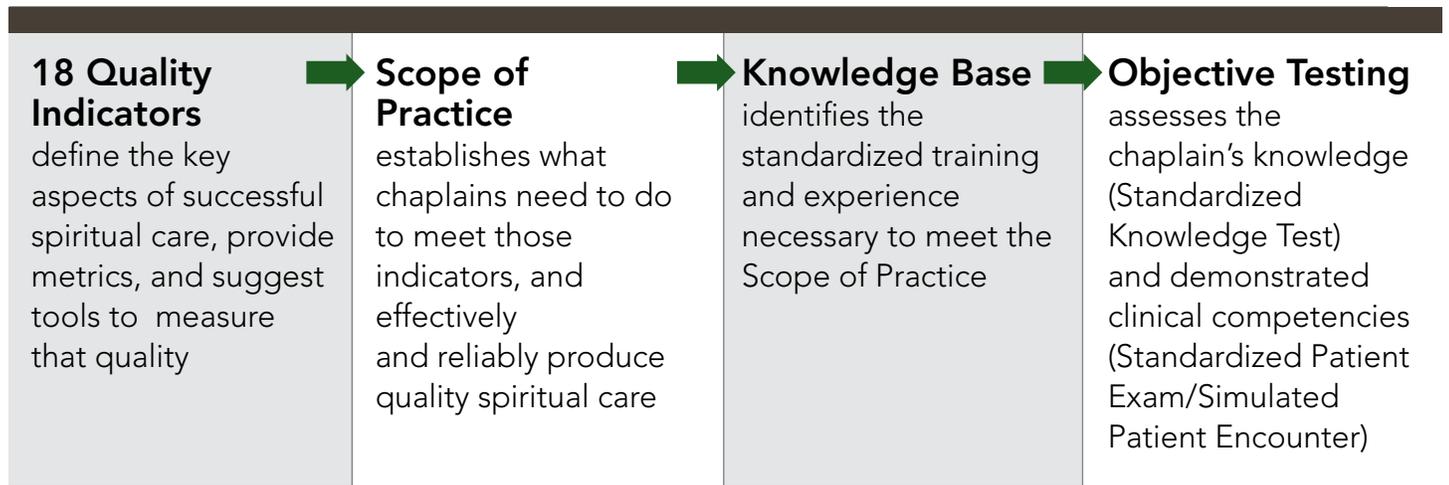
From a chaplain:

“I feel like I’m finally being recognized that what I do matters. I’m finding a home where I can have community and learn more.”

MAKING SPIRITUAL CARE A PRIORITY

SCA, an affiliate of the 57-year-old HealthCare Chaplaincy Network, marks the culmination of decades of **experience, research, discussion, and insight** from respected leaders, daily providers, and others interested in spiritual care and chaplaincy.

OUR EVIDENCE-BASED MODEL



OUR STANDARDIZED KNOWLEDGE TEST AND SIMULATED PATIENT EXAM:

- Bring to the profession of health care chaplaincy the same rigor in education, training and testing demanded by other health care disciplines
- Establish the framework for an ongoing process of implementation, research, and quality improvement

OUR STANDARDIZED KNOWLEDGE TEST AND SIMULATED PATIENT EXAM:

Currently, more than a dozen chaplaincy groups within the U.S. offer varying education/training, however, no other organization that trains and certifies chaplains can demonstrate the use of a standardized, evidence-based curriculum nor the scoring of knowledge and competency tests. **This is the SCA difference, and represents a higher bar than any other chaplain certification processes.**

From a chaplain:

“**Boldly taking the leadership in areas of direct interest to me and our profession ... The upgrade of standards for a ‘new age’ is very welcome.**”

USING THIS GROUNDBREAKING AND TRANSFORMING EVIDENCE-BASED MODEL, SCA OFFERS CHAPLAIN CREDENTIALING AND ADVANCED PRACTICE BOARD CERTIFICATION

Advanced Practice Board Certified Chaplain (APBCC) is a chaplain who has demonstrated advanced skills in the provision of and leadership in spiritual and chaplaincy care by successfully completing a test of core knowledge derived from evidence-based quality indicators for spiritual care as well as a simulated patient exam that evaluates competency in direct patient care. Advanced Practice Board Certified Chaplains (APBCC) have been trained and tested in standardized curriculum based on the latest evidence in areas including department management; HIPAA regulations; the assessment, diagnosis, and treatment of spiritual distress; cultural competency; advance care directives; patient clinical care; staff support; grief; and bereavement among other essential topics.

Board Certified Chaplain (BCC): The designation of Board Certified Chaplain will continue to be maintained by the SCA. Current BCCs will have to take the core knowledge test around the time of their 5-year anniversary to maintain their BCC. At any time, BCC chaplains may choose to apply and test for APBCC designation.

Chaplain Credentialing is for those working as chaplains who are not board certified, and meet SCA's requirements, which include a Bachelor's degree in a content area relevant to chaplaincy, at least 400 hours of clinical pastoral education, and successful objective testing.

SCA's innovative approach to chaplain training, credentialing, certification, and continued education incorporates the desires and issues raised by those in the field, administrators, researchers, and thought leaders over decades. The Spiritual Care Association:

- Provides education: clinical training for students, continuing education for chaplains and specialized education for other health care disciplines based on a knowledge base founded in the latest research and updated as new evidence and needs appear.
- Brings chaplaincy to the level of training and demonstrated clinical competencies required by other professional disciplines, including doctors, nurses, social workers and therapists, responding to the need for training to be tested, and relies on standardized testing and a simulated patient experience to demonstrate clinical competency, knowledge base, and best practices.
- Opens professional chaplaincy to capable and competent individuals, who can now enter the field through various pathways while ultimately demonstrating the required degree of knowledge and competency. By providing pathways for credentialing and certification that focus on knowledge and demonstration of skills, many who have been unable to meet the requirements that do not consider culture, belief tradition, geographical location, age, and financial resources will now be able to be trained, credentialed or certified, and continually educated to provide the best care for those whom they serve in their care systems.

From a chaplain:

“It's about time! Thank you for putting this together. It really is the future of chaplaincy at stake.”

NCP Clinical Practice Guidelines — Impact on Care for the Spirit



“Palliative care is not end of life care; it is quality care for anyone with a serious illness.”

**Dr. Betty Ferrell, Ph.D.,
RN, FAAN, FPCN, CHPN.**

Director & Professor Nursing
Research & Education
City of Hope

Feel empowered to advocate for better spiritual care; as Kathy indicated in her broad view of what is happening in the world, there is a strong foundation. The 4th Edition of the NCP Clinical Practice Guidelines for Palliative Care give spiritual care providers a tool for building on that foundation and ensuring quality care. Read the Guidelines: Everything is available online with resources for use. <https://www.nationalcoalitionhpc.org/ncp/>

- Palliative care is not end of life care; it is quality care for anyone with a serious illness.
- An interdisciplinary care delivery system designed for patients, their families, and caregivers
- Beneficial at any stage of a serious illness (not just for those who are dying)
- Anticipates, prevents, and manages physical, psychological, social and spiritual suffering to optimize quality of life
- Delivered in any care setting through the collaboration of many types of care providers
- Improves quality of life for both the patient and the family through early integration into the care plan (quote is: Palliative care... improves quality of life for both the patient and the family through early integration into the care plan)



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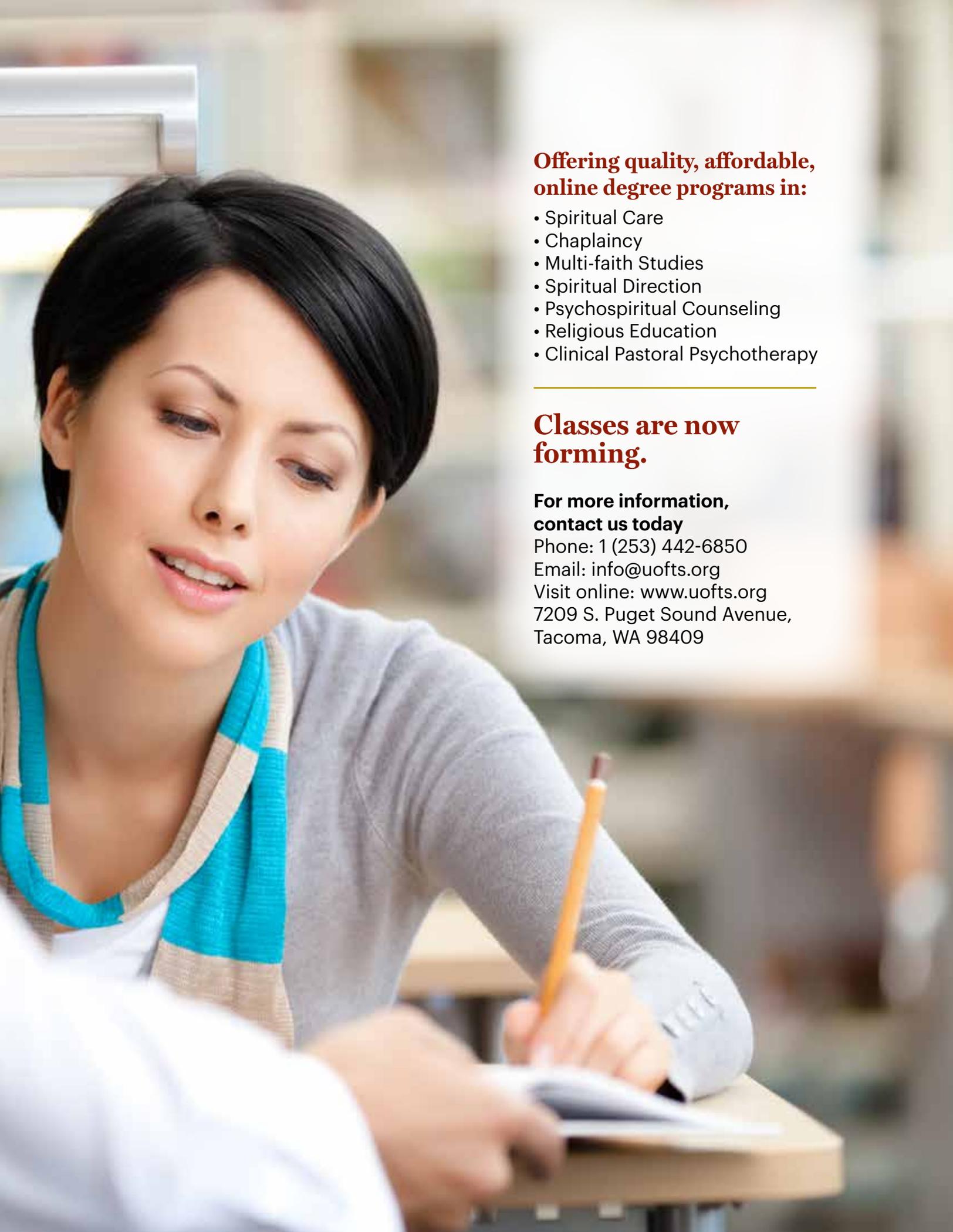
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Key Concepts

- Person- and family-centered approach to care
- Inclusive of all people living with serious illness, regardless of setting, diagnosis, age, or prognosis
- A responsibility of all clinicians and disciplines caring for people living with serious illness

Other disciplines should not ask “Do you want to see the chaplain?”

- Introduce the team of which the chaplain is a full member and the specialist in spiritual care
- If patient does decline chaplaincy services, it is the responsibility of all clinicians to provide generalist spiritual care and look for opportunities to reintroduce spiritual care at a time of crisis, even if persons initially declined chaplaincy?
- Teach disciplines to develop trust with a patient, then introduce spiritual care/chaplain again

Serious illness – A health condition that carries a high risk of mortality and either negatively impacts a person’s daily function or quality of life or excessively strains their caregiver. Kelley AS, Bollens-Lund E. Identifying the population with serious illness: the “denominator” challenge. *Journal of Palliative Medicine*. 21(52). 3/1/18. <https://www.liebertpub.com/doi/10.1089/jpm.2017.0548>

NCP Guidelines provide a structure to move palliative care forward, including the essential elements for standards, policies, and best practices. Developed by the National Consensus Project, which includes numerous stakeholders, including chaplaincy (HealthCare Chaplaincy Network and the Association of Professional Chaplains). Endorsement of the Guidelines has been done by more than 80 organizations.

The NCP Guidelines have 8 essential domains, of which Spiritual, Religious, and Existential Aspects of Care is Domain 5. Each domain addresses the 6 C’s

- Comprehensive assessment – are spiritual assessments comprehensive?
- Care coordination – how is coordination of spiritual care done between organization and community?
- Care transitions – from setting to community
- Caregiver needs – should not be left out of spiritual care even if patient does not want services
- Communication – what are providers most comfortable speaking about, i.e., medications, withdrawing care, sexuality, spirituality, etc. Spirituality is rated as the topic clinicians are most uncomfortable talking about. How

are providers trained to be more comfortable? Are chaplains included in training, orientation, education about communication?

- Spiritual Care Specialist and Spiritual Care Generalist Model: Making Health Care Whole: Integrating Spirituality into Patient Care: Christina Puchalski and Betty Ferrell. 2010. Templeton Press. ISBN-10: 159947350X.

- Cultural inclusion – Organizations are not committed to cultural diversity if they are not committed to spiritual care; it is a part of culturally respectful care

Integrating spiritual care into day-to-day provision of palliative care can be done by integrating the domains

- Domain 1: Structures and Processes of Care - How can good spiritual care happen routinely? If organizations are not providing excellent spiritual care, they are not providing excellent palliative care
- Domain 2: Physical Aspects of Care – Begins with understanding patient goals in the context of physical, functional, emotional, and spiritual. Make sure spiritual assessment is part of all physical aspects
- Domain 3: Psychological and Psychiatric Aspects of Care - Where are spiritual needs and spiritual distress in these assessments?
- Domain 4: Social Aspects of Care – Spirituality is part of the social determinants of health
- Domain 5: Spiritual, Religious, and Existential Aspects of Care – Spirituality is fundamental and part of all disciplines’ care. All spiritual care providers should read this section in detail. Take these guidelines back to your organization to see how their programs are doing. Where are the opportunities?
- Domain 6: Cultural Aspects of Care – First step to assessing and respecting values, beliefs, and traditions – diversity in every form. How good is our care for anyone who is different from the dominant culture in our organization?
- Domain 7: Care for the Patient Nearing the End of Life - Comprehensive assessment of physical, social, spiritual, psychological, and cultural aspects of care. Go back and pull the charts of the last 20 people who died in your organization. What did that care look like? Was there any recognition of spiritual needs? Was a chaplain present? Was there a plan for bereavement and spiritual support of the family?
- Domain 8: Ethical and Legal Aspects of Care – Look at last 20 consults ethics committee has done in your organization. How many of those included spiritual and/or cultural issues that led to the crisis?

Blending Humanistic and Economic Outcomes to Make the Case for Spiritual Care



“Executives focus on length of stay and economic costs as well as outcomes; how do chaplains speak this language?”

Dr. J. Brian Cassel, Ph.D.

Palliative Care Research Director
Virginia Commonwealth University

Tensions and paradoxes:

- Outcomes of interdisciplinary team and uni-disciplinary role
- Required but seemingly optional role of chaplains
- Efficiency without industrialization or commodification

Tremendous value of chaplains

- Willing and able to take the time needed for listening
- Preserving dignity, support expressions of forgiveness, gratitude, love, promoting wisdom, reducing distress, helping with coping, grieving, capturing legacy
- Providing team-based personalized precision medicine
- Bridging gaps – science and religion, hopes and fears, alienation, incoherence
- Supporting health care teams
- Reaffirming the need for non-industrial models of care
- Community engagement – overcoming distrust, denial, misconceptions

Integrate economic, clinical, and spiritual outcomes

- Need to design services before moving ahead to outcomes in order to evaluate delivery

Framework for Evaluation

Design and Deliver Service: Patient, Social, Institutional

- Patient-centered, family-oriented
- IDT: bio-psychosocial-social-spiritual needs
- Assess and manage symptoms
- Elicit goals and evaluate options
- Excellent communication, navigation

Evaluate Delivery of care by all providers

- Who: Referring providers, IDT, and patient characteristics
- When: Timing of service relative to other events
- Where: Locations, settings
- How: Expertise, techniques, time spent, costs
- How much: Frequency, duration, intensity, breadth, costs
- How well: Standards met? Gaps in quality? Sustainable?

Evaluate Service Outcomes

Evaluate impact on patients

- Biological, psychological social, spiritual needs addressed?
- Pain, other symptoms, distress are prevented and reduced?
- Subsequent care is effective, goal-concordant, not burdensome?
- Patient experience is positive?

Evaluate impact on families and referring providers

- Family – less confused, less distress, positive experience?
- Nurses, doctors – appreciate specialist help, less distress?

Evaluate impact on payers, systems, sponsors

- Shift and reduce costs?
- Improve institutional quality and performance metrics

Executives focus on length of stay and economic costs as well as outcomes; how do chaplains speak this language?

- *Core skill:* To take seriously responsibility to demonstrate one's own outcomes including financial. Local data trumps research. Research needs to include not only clinical outcomes but financial

- Empathize with CFOs, executives, etc. to understand their goals and help achieve better outcomes to orient what happens next to fit into those goals. Working with executives is like doing a family meeting. Two-way relationship to understand the value of what each other does.

Translate evidence from health services research into strategic planning Translating outcomes into finances

- Improved patient experience
- Reduced length of stay per admit
- Avoid (make unnecessary) some hospitalizations
- Survival, safety, quality
- Reduce overall cost per patient over time

Chaplains and program evaluation

- Where are IDTs and chaplains in outcomes?
- What immediate and longer-term effects do spiritual care interventions have on patients, caregivers, healthcare teams, utilization, and cost?
- What the outcomes of programs (such as palliative care) are with complete vs. incomplete teams?
- The risk of social-political goals versus scientific goals: What if your research shows that spiritual care is “nice” but doesn't translate into lower costs, higher revenue, and other outcomes that sponsor-funders want? What next?
- Imperative for involving chaplains in program evaluation

If you are not already doing community engagement around public health issues including serious illness, death, grief, suicide, etc., these are areas to become involved in. Cannot emphasize enough how important it is to move upstream and work with these issues before people are engaged in health care with serious illness/death

Summary:

- Evaluate and describe your value within and beyond area where working (such as palliative care/hospice)
- Emulate strategies used in the field (such as palliative care) to acquire sustained funding and widespread adoption
- Align patient-centered outcomes with the business interests of funding partners
- Transform the culture of health care and U.S. society to be humanized rather than industrialized

The Spiritual Care Profession: Mandated or obsolete?



Cheryl Holmes, OAM

Chief Executive Officer
Spiritual Health Victoria

“The primary value of chaplain presence that clinicians name is the ability to hold the big picture, i.e., of patient and family emotions, values, and beliefs. This is challenging work. We need each other on the team.”

The Australian Context – increasing religious diversity and increasing “spiritual but not religious”

THE CHANGING AUSTRALIAN CENSUS

	1996	2006	2011	2016
Anglican	22.0%	18.7%	17.1%	13.3%
Catholic	27.0%	25.8%	25.3%	22.6%
Other Christian	21.9%	19.3%	18.8%	16.3%
Other religions	3.5%	5.6%	7.2%	8.2%
No religion	16.6%	18.7%	22.3%	30.1%

Health Care in Australia is funded and administered by the government and supported by a number of optional private insurances

- Person-centered care, patient reported outcomes, and patient experience
 - Beliefs and values
 - EOL care providing for the cultural, spiritual, and psychosocial needs of patients, their families and carers are as important as physical needs
 - Spiritual care and pastoral care workers are included in multidisciplinary teams
- Quality and safety emphasis – distinctively clinical in its standards

Spiritual Care in Australia

- Spiritual Care Australia – state based, various models, professional chaplains, faith specific chaplains and volunteers
- No consistent standards for training although CPE is seen as standard
- Research minimal although becoming more important
- 2014 SCA Standards are not mandated; need to be updated

Spiritual Health Association

- Mission: enabling the provision of quality spiritual care as an integral part of all health services
- Publications: Capability Framework for Spiritual Care Practitioners in Health Services 2016; Spiritual Care in Victorian Health Services: Towards Best Practice Framework 2016; Spiritual Care in Medical Records: A guide to reporting and documenting spiritual care in health services 2019
- Stakeholder Views on Spiritual Care in Australian Hospitals 2017
 - Summary: What a national policy agenda will require
 - Stakeholder views on the role of spiritual care in Australian hospitals: An exploratory study. Holmes C. Health Policy 122(4) April 2018. <https://www.sciencedirect.com/science/article/pii/S0168851018300460?via%3Dihub>
- National Consensus Conference 2017
 - 68 participants from state governments, universities, national peak bodies, state peak bodies, health service executives, spiritual care practitioners and educators
 - Outcomes and policy statements - many reflected the 2016 Quality Indicators developed by an international panel and published by HealthCare Chaplaincy Network

Challenges

- Defining spiritual care. *Spiritual care is the provision of assessment, counseling, support, and ritual in matters of a person's beliefs, traditions, values, and practices enabling the person to access their own spiritual resources*
 - What is needed is a definition for those receiving care; patients talk about SC as providing a safe space, listening, counseling, human connection at a difficult time, existential support
 - Chaplains talk about SC as "presence" not sure how helpful that is without unpacking what it is; needs to be intentional otherwise the chaplain may be "taking up space"
- Who is responsible for spiritual care?
 - Historical role of churches and faith communities – does the responsibility still lie there?
 - Health services, governments – who pays for it?
 - Where does accountability lie? Should there be a shared responsibility? Is that possible
 - Does how one defines SC and how it is practiced influence this question?
- What does spiritual care practice look like?
 - A Christian paradigm can no longer frame how the profession is viewed in light of religious diversity and rise in spiritual-but-not-religious
 - Role of volunteers in light of organizations desperate for resources
 - What is best practice spiritual care
- Outcomes
 - Both processes and outcomes are important
 - "Chaplains are without an agenda" – if chaplains have no agenda, should they be in the room at all?
- Certification
 - No certification process in Australia – challenge is to identify requirements and process; have partnered with Spiritual Care Australia
 - Requirements do not include faith endorsement due to non-religious practitioners and persons receiving care
 - Looking at possibility of knowledge test and some sort of reflective exercise. Educational pathways – practitioners in Australia have come into profession due to all sorts of degrees with common denominator of CPE; that diversity adds to richness of profession however raises question of what is core educational pathway. Could that be CPE?
 - CPE in Australia needs to get rid of its inconsistency; need evaluations of programs and evidence of its outcomes; what does CPE contribute to a skilled practitioner and what else is needed

- If theology is no longer the core knowledge, what is? How do we think about formation?
- Emerging opportunities
 - Person-centered care – Spiritual needs should be recognized and responded to as an integral part
 - Importance of addressing moral injury among veterans, health care providers, others <https://www.reuters.com/investigates/special-report/witness-yates-injury/> -

“The strongest voice for spiritual care will come from those who have experienced it.”

Workshop: Patsy Fortney and Priscilla Minkin, Chaplains, Central Vermont Medical Center

The Words We Use: Bridging the Gap between Medical and Spiritual Care with Confidence, Respect, and Compassion

List concrete values of confident chaplaincy to clinicians, patients, family members, and chaplains

- Honest recognition of, and accounting for, one’s own reactions in the moment
- A solid place to stand from which one can be open to the realities of others, breeding humility
- Not territorial, does not push back, have agenda, or need to be right
- Where do I stand in relation to my own authority? Not Am I allowed in their space?
- Working with medical team members, what can we do to uplift that team member in their work? How can we support the big picture?

Value of confident chaplaincy to the medical team

- Translating patient experience, values and where life holds meaning helps the team to better understand the person being treated and align care with patients’ values – not just their religious affiliation and faith community
 - **Questions to elicit values**
 - What is your understanding of why you’re here? If patient or family doesn’t know it is good information for physician to know
 - When thinking about the future, what is most important to you?
 - Where does life hold meaning? What causes you to smile?
 - What gives you strength? What nurtures your spirit? What gives you hope?

- What worries you? What frightens you?
- Have you had experience with serious illness before? A loved one dying?
- Tell me more. Anything else?
- Spiritual care notes can guide physician conversations about goals of treatment
- All providers can experience less isolation and more resilience when they work in an environment of trust and support

Value of confident chaplaincy to patients and families

- Explore emotions around serious illness to help patients and families voice feelings, desires, and concerns
- Communicate concerns, questions, and wishes to the medical team
- Clarify with what they are hearing from the medical team
- Help process information

Describe specific actions that can increase chaplain confidence, and by extension, the relevance of chaplains on the medical team

- Attend rounds regularly and speak up respectfully
- Learn and use medical terminology
- Model quality spiritual care everywhere; use the language of spiritual care
- Write chart notes that are helpful to the entire IDT; ask the staff
- Write and distribute a spiritual care brochure for staff to help know and explain what the chaplain does
- Have and use an elevator speech
- Build relationships with staff
 - Go where they go (cafeteria, break room, hallway)
 - Affirm their work
 - Let staff know what you can provide for them
 - Report to them in person
 - Ask how best to support them

Analyze the emotional content inherent in confident, respectful communications between chaplains and the medical team and have five questions and statements that can be used immediately with medical staff

- *I know this patient well. Would it be helpful if I went in with you?*
- *Do we know anything about her goals of care or values?*
- *Am I hearing we’re worried this patient could die?*
- *I know we’ve said it, but I think it would help the patient and family to hear it again.*
- *May I ask, how sick is the patient?*



A Hospice Chaplain's Journey to Board Certification

By Jim Andrews, MA, APBCC, HEC-C

May 13, 1998. That is the date I was first hired to work for a hospice program. At that time, I didn't even know what a board-certified chaplain was, much less have any aspirations to become one. Initially, I was hired as a professional development coordinator, creating curricula and providing training and continuing education for staff and volunteers. In this role, I was required to immerse myself in hospice history and philosophy, so that I could prepare new staff members and volunteers coming in to the organization for the sacred work that they were about to do. My own orientation involved shadowing nurses, social workers, hospice aides and chaplains as they met with dying patients and their families.

I'll never forget the day I shadowed the chaplain. We made a visit to a family whose loved one had just died. This was a deeply religious family, and the patient had been the mother and grandmother who everyone looked to for inspiration and guidance. She was the heartbeat of that family, and from the time of admission, they had been very distraught about her impending

death. We arrived moments after she took her last breath, and her children and grandchildren were devastated and tearful. I remember feeling my anxiety level rise as I surveyed this chaotic and extremely emotional landscape. My heart ached for them. At the same time, it made me very uncomfortable to be near the body. I felt a powerful urge to mumble some apology and excuse myself. Then, in the midst of all of that I looked at the chaplain.

What stood out to me wasn't really what he was saying. It's hard to remember anything in particular that he actually said at the time. It was the quality of his presence that drew me in. There was an unhurried, peaceful, centered, focused and deeply compassionate demeanor emanating from him. He really saw these hurting family members. He truly heard them. He was a witness to their grief and pain and disillusionment. He validated their reality. He met them at their point of need and had the spiritual fortitude to join them in that painful place without giving in to the urge to minimize it, or try to make it go away, or find a silver lining.

That's when I realized I had come to hospice looking for a job and ended up finding a vocation. Fortunately, my education and background met the requirements at the time for becoming a chaplain. When I transitioned into my new role, a wonderful cadre of hospice chaplains showed me the ropes. There were also amazing hospice nurses, social workers, aides and volunteers who helped me to see how an interdisciplinary team worked, and they got me up to speed on all of the regulatory requirements and medical jargon needed to be able to collaborate effectively. I learned about criteria for admission and recertification, levels of care, the trajectory of decline for various diseases, and what to expect when a patient becomes imminent and begins actively dying. There is such richness in the hospice philosophy of care, and it provided a firm foundation for serving as a chaplain.

It wasn't until I had been working as a hospice chaplain for several years that I learned about Clinical Pastoral Education (CPE) and the board certification process. At that point, my reaction was somewhat guarded. What do I need all that for? I've been doing the job for all these years without it! But, at the urging of a colleague who had finished her first unit of CPE, I decided to give it a try. Fortunately, the hospice I was employed with fully supported this important professional development.

CPE was difficult but rewarding work. It is as much an exercise in formation as it is education. The process of offering ministry and then reflecting systematically about the encounter with a group of peers provides a unique opportunity to discover blind spots and become aware of all of the ways that our personal history either supports or impedes our effectiveness. As I continued to progress in CPE training, it became increasingly clear to me: being an effective hospice chaplain goes beyond having a heart for ministry or even having a strong

grounding in hospice philosophy. We need to have command of a body of knowledge and a set of skills that are specific to our profession and require intentional cultivation.

Even after completing four units of CPE, I remained somewhat hesitant about board certification. I had seen posts on social media and heard other hospice chaplains discussing the whole question of whether the board certification process really added value. Why go through all the additional work of study and preparation? For me, it finally came down to the patients and families we serve. We owe it to them to not only be compassionate, but competent as well. Hospice chaplains are entrusted with profound and sacred work, and the stakes are too high, and the scope of learning too broad, to leave it to chance that we will pick it all up on the job. We should be willing to have our competence assessed. We should be committed to continued education, growth and development. We should be connected with and contributing to our profession. Going through a board certification process is making a personal commitment to professional excellence. I had started preparing for board certification a number of times, but it always seemed that work and life got in the way. However, when the Spiritual Care Association developed a path to board certification that involved a standardized knowledge test and a simulated patient exam, I made the commitment to see it through. I'm so glad that I did.

The requirements for being a chaplain with hospice programs around the country still widely vary. There are small hospices who look to community clergy to meet the spiritual needs of their patients and families. Other hospices employ chaplains but accept their good standing in their faith community as sufficient indication of their readiness to serve as a chaplain. Still others require at least some clinical pastoral education and

official endorsement from a faith community. Few hospice programs require board certification. I think the time has come for us to raise the bar. The time has come to expect the same level of preparation and professional certification for hospice chaplains that is required of all the other members of the interdisciplinary team.

It's been a long journey from those early days of discovering a new and wonderful vocation. I feel so grateful for the tremendous trust that is extended to us by those we serve to provide spiritual support through such difficult times in their lives. I feel proud of the sacred work that we do as chaplains and the incredible impact that it can have on people's lives. And I feel personally committed to recognizing and promoting board certification as essential credentialing for our work. So, even if your organization doesn't currently require it, I would encourage hospice chaplains to pursue this very worthwhile goal. Your patients and families, and the organizations you serve, will benefit almost as much as you will.
Blessings on your journey!

.....
Rev. Jim Andrews has worked in the hospice industry for over 20 years and currently serves as the Director of Spiritual Care with Suncoast Hospice, a member of Empath Health. He is an Advance Practice Board Certified Chaplain with the Spiritual Care Association, Commissioned/Ordained with the Federation of Christian Ministries, a Certified Health Care Ethics Consultant with the American Society for Bioethics and Humanities, and a Green Belt in Lean Six Sigma. Jim is dedicated to demonstrating, developing, and advocating for the continued impact of chaplaincy and spiritual care in the hospice setting.

A HOMECOMING

Working as a Staff Chaplain at **Memorial Sloan Kettering**

By **Molly O'Neil Frank, M.Div., BCC**

Being hired as a staff chaplain at Memorial Sloan Kettering has been like coming home. I first stepped through the doors on York Avenue and 68th Street in Manhattan when I was 28 years old. Recently married, I was running a small Off-Off Broadway theater company on the Upper East Side, and although I loved what I was doing, I was also grappling with the fact that my mother had recently had surgery and completed a course of treatment for Stage III breast cancer at MSKCC. I felt a strong desire to give back to the hospital that had saved my mother's life, so I volunteered once a week in the admissions area at the bottom of the escalator. That was nearly 30 years ago, and although Memorial has grown exponentially, the scale and feel of the building at 1275 York Avenue is very much the way it was when I was starting my career as a theater producer.

When my oldest children were preparing to go off to college, I too felt that I needed to make a transition. I was no longer as engaged in the work I had been doing. Now that my children had grown more independent, I had begun to ask myself, what do I drop everything to do? What do I care about most? After my mother died

in 2003, I started to accompany my friends to their chemotherapy treatments. I was in my mid 20s when my mother was first diagnosed with cancer, and I was in my early 40s when she finally died from the disease. During that time, I learned that no one should have to be in treatment alone. I wanted to "lean in" as a witness and a friend, to simply sit beside someone to provide a distraction and let them close their eyes when IV lines were being administered.

My desire to be with patients who were facing life-limiting illness led me to become a hospice volunteer at Visiting Nurse Service. I began to realize that the role of the witness, accompanier, supporter, listener, spiritual care provider had a name: "Chaplain." Over the course of a year, I spoke to doctors, social workers, priests, ministers, rabbis, psychologists and chaplains about the role of the spiritual care provider and the path towards becoming properly accredited.

My call to this work led me to Union Theological Seminary and the office of Rabbi Mychal Springer at The Jewish Theological Seminary in New York City, where I did my first unit of clinical pastoral education. To say that the work was lifechanging for me would be an

understatement. My first unit of CPE with two rabbinical students, a Catholic priest and three Christian seminarians of different denominations allowed me to explore my own sense of God in increasingly creative and ecumenical ways. I received my master's in divinity (or master of divinity) from Union in 2016 and completed my clinical pastoral training at Columbia Presbyterian Weill-Cornell Medical Center in 2017. While I was there, I had the opportunity to work with patients old and young, facing medical challenges from routine to profound, as I learned with other CPE students who came from traditions as diverse as our own New York City population.

Historically, the role of the chaplain has been considered to be a part of the pastoral care role of clergy, and yet the Judeo-Christian roots of chaplaincy feel anachronistic. In the 21st century we have hundreds of religions that spread out far beyond the three Abrahamic traditions. Increasingly, spiritual care providers encounter patients who are "spiritual but not religious" or who are a part of the growing "nones" movement. I have met chaplains who are Humanist or even Atheistic. Whether someone has a strong adherence to a faith

tradition or whether they are a proclaimed atheist, the animating energy of that person is being tested by their illness.

Working as a staff chaplain at Memorial Sloan Kettering Cancer Center is one of the great privileges of my life. Cancer is a terrible and powerful teacher. As a patient loses control over their body, the mundane begins to shine, and the way that they love and receive love can become clearer and deeper. Some call this transcendence; I explore this experience with my patients, even in silence. In this sense, I believe that the divine is in the relationship itself. When a patient finally relinquishes control of the outcome and acknowledges the mystery of interconnected lives and the love of family, friends and community, the potential to unleash the pastoral imagination becomes possible. In that space, God allows me to hold my patients' sense of poignancy and ambivalence while meeting them where they are and surfacing their hope for whatever the future may bring.

Thirty years ago, I never would have predicted that I would be at MSKCC as a staff chaplain, and yet it feels as if I have been preparing to do this work for my whole life. It is an honor to connect with patients and their families as they grapple with the profound life changes and uncertainty that a cancer diagnosis brings, and I am grateful to my patients every day for teaching me what it means to have strength and purpose in the face of life-limiting illness.

Molly O'Neil Frank is a staff chaplain at MSKCC. She has her Masters of Divinity from Union Theological Seminary, is a member of the Association of Board-Certified Chaplains, and is a candidate for postulancy for ordination in the Episcopal Church.



The *Caring for the Human Spirit*[®] Conference is the premier spiritual care forum for cutting-edge topics to enhance your spiritual care practice and ministry. The three-day event features a keynote address, plenary sessions, and more than 35 workshops to choose from. There are also four optional pre-conference intensives available, as well as an all-day cultural immersion experience in the greater Santa Fe area.

KEYNOTE SPEAKER

Fr. Richard Rohr, OFM

Granger Westberg Keynote Address:

Presenting: Tracking the Perennial Tradition Creates an Alternative Orthodoxy

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- Networking Opportunities

For more information and to download the Conference Brochure, please visit
<https://spiritualcareassociation.org/conference>



Thinking About Becoming a Health Care Chaplain?

The Health Care Chaplain Division of the Spiritual Care Association focuses on the spiritual dimension of professional health care chaplains in a number of varied clinical settings. SCA, in partnership with its 60-year old affiliate, the HealthCare Chaplaincy Network (HCCN) supports the advancement of health care chaplaincy and spiritual care as an integral aspect of whole person care for all.

Benefits of Membership

- Belong to a supportive professional community that welcomes both novice and seasoned health care chaplains
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Therapeutic Storytelling

Uncovering the Inner Narrative

By Scott Janssen, LCSW

As a hospice social worker, I spend lots of time listening to stories told by terminally ill patients. Some stories look back on lives patients have lived, teasing out lessons they've learned and relationships that have been important, others anticipate the future or attempt to put into words what is happening in the present.

Often these stories reveal deeper, sometimes unconscious, inner narratives woven from a patient's life experiences, values, hopes and fears; narratives which define how patients see themselves and the world around them. Not surprisingly, these deeper narratives influence the way patients view their circumstances and can shape the way they respond. When these deeper stories reveal themselves while I'm with a patient, a question often arises: Are they helping or hindering that patient in using what time remains in a way that is meaningful, and which allows the patient to express what is in his or her heart?

Therapeutic Storytelling

For patients who find that these narratives are hindering them—for example, an inner story that justifies

anger or resentment, or interferes with a wish to forgive—I often offer a “therapeutic story” in the hope of fostering insight, growth or healing.

The right story can shift a patient's perspective in positive ways and help him or her access strengths and coping resources. It can engage the patient's creativity and ability to envision new solutions to seemingly intractable challenges. Telling patients a story allows them to step back from frustrating patterns and/or intense emotions and look at things from a safe distance without judgment, perhaps offering novel ways of thinking about—or important images or metaphors for understanding—a particular impasse.

Despite evidence attesting to the potential benefits of therapeutic storytelling, (Burns, 2001; Hammel, 2018; Lankton & Lankton; 1989; Rosen, 1991) it was not part of my training as a social worker. I learned about these benefits from chaplains who seemed to have the knack for matching a patient's struggles and circumstances with anecdotes, parables, fables and stories from the world's spiritual traditions.

Perhaps this is not surprising given the way diverse spiritual

traditions have, from their earliest origins, used stories to convey principles and values, and to illustrate how one might face—even thrive during—times of adversity. In his *Handbook of Therapeutic Storytelling: Stories and Metaphors in Psychotherapy, Child and Family Therapy, Medical Treatment, Coaching and Supervision*, Hammel points out that the “writings of the Old Testament prophets, the parables of Jesus and the stories of the rabbis deal with spiritual pedagogical and social therapy problems while simultaneously entertaining listeners. Throughout all of Christian, Jewish and Muslim history, metaphors have been deliberately used as effective prompts for problem solving.”

Following the lead of my chaplain friends, I've borrowed and integrated stories into my clinical work from mythology, folklore, literature and sacred texts from around the globe. I've also drawn them from nature, science and sports, as well as from my own life and the lives of patients and caregivers. As the following vignette illustrates, though, some of my favorite stories come from world history.

The Tale of the English Long Bow

Bill prized strength and decisiveness. To his family, he was demanding and inflexible. Whenever things didn't go his way, he'd lash out in anger. Unfortunately, his precious strength was fading as cancer attacked his lungs and he was becoming increasingly dependent on others for help. The weaker he got, the more intense his rage seemed to become. As a result, his adult children avoided him and his wife walked around on eggshells waiting for the next explosion.

Talking with him about his anger and the way it had driven a wedge between him and his family, I asked if this was how he wanted to live the last part of his life. Instead of reflecting on this he launched into a diatribe blaming his family for his anger and giving me examples of their behaviors, which he thought proved his point.

"Do you know anything about English long bows?" I asked, intentionally interrupting him in the hope of jarring him out of this familiar pattern of blaming others.

It got his attention. In his younger days he'd been a bow hunter and a member of a local archery club. English long bows were famous. They had been decisive, after all, during the clashes between England and France during the Hundred Years War. Bill seemed curious where I was going with this abrupt change of subject.

After telling him about how bowmen trained from childhood to use the bows, I worked my way toward a metaphor I hoped might strike a chord. Few trees, I told him, had the properties needed to construct a bow with this kind of power. Though ash and elm might do in a pinch, the wood of choice came from the yew tree.

Craftsmen would select a section of yew wood that combined the strength of its heartwood for the inside of the bow stave and the pliability of its sapwood for the outside. The trick was to fashion a stave that possessed uncommon strength and resistance on the one hand, and flexibility and the ability

to bend on the other. Too much strength and resistance would make the bow impossible to draw and risk its breaking if placed under enough pressure. Too much flexibility would reduce its power and range.

I suggested to Bill that he had too much heartwood and not enough sapwood. His strength and rigidity needed to be balanced with flexibility and the ability to bend. Otherwise he was wasting his power and sooner or later something was going to break.

The story engaged his curiosity and imagination in ways that allowed us to have a serious conversation about his temper without his becoming defensive, as had happened on prior visits. The image of strength combining with flexibility made sense to him and gave him a mental picture in a way that more process-oriented conversation had not.

Moreover, the story was a nonthreatening way to open a door to further conversation in which Bill was able to reflect on what was underneath his anger—sadness, feelings of guilt at not being able to protect his family, shame at his inability "to beat this damn cancer." In the weeks that followed, although he continued to lose his temper now and then as his illness progressed, he frequently returned in his mind to the metaphor of the power of the sapwood's flexibility and capacity to give ground.

Transformative Power at the End of Life

The challenges of dying are many. Intense emotions, punishing fatigue, loss of independence, distressing physical symptoms, the sadness of separation or regret and the swirl of unanswerable questions can be overwhelming. Words can easily fail. Energy can quickly flag.

Having a story to share can be a good way to give patients a break from talking about places they are feeling stuck. The act of sharing a tale can create an enhanced sense of connection and trust. At times, it can introduce an element of levity, placing challenges and human

imperfections into a context in which they are not so insurmountable after all. The images, symbols and metaphors in stories, when matched with a patient's situation, language and experience, can reach into the psyche in ways that words cannot, creating positive shifts in understanding or feeling states.

As a social worker I'm trained in various models of psychotherapy, crisis intervention and strategies for facilitating difficult conversations. When sitting with a patient who is struggling with painful emotions or beliefs, or who is feeling trapped in old patterns, I have plenty of strategies for helping them find a way forward. One of the most indispensable, if timed and chosen well, is the simple and often transformative power of stories.

Burns, G. (2001). *101 Healing stories: Using metaphors in therapy*. New York, NY: John Wiley & Sons.

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Lankton, C. & Lankton, S. (1989). *Tales of Enchantment: Goal-oriented metaphors for adults and children in therapy*. Bristol, PA: Bunner/Mazell.

Rosen, S. (1991). *My voice will go with you: The teaching tales of Milton H. Erickson*. New York, NY: W. W. Norton.

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Scott Janssen is a clinical social worker with UNC Health Care Hospice in Chapel Hill, North Carolina. His book *Standing at Lemhi Pass - Archetypal Stories for the end of Life and Other Challenging Times* explores the use of Therapeutic stories with terminally ill patients and their loved ones.

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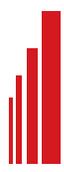
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