A DACUM Analysis of Health Care Chaplains in Metro New York and the Implications for Clinical Pastoral Education

A Dissertation submitted
to the Graduate School
Valdosta State University

in partial fulfillment of requirements
for the degree of

DOCTOR OF EDUCATION

in Curriculum and Instruction

in the Department of Curriculum, Leadership, and Technology
of the Dewar College of Education and Human Services

August 2017

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ABSTRACT

Until now, there has not been a single, accepted profile of the role of health care chaplains. De Vries, Berlinger, and Cadge (2008) clearly identify the issue when they say, the specific duties and responsibilities of their job are ill-defined.

The duties and tasks were defined by consensus in this study using a widely used occupational analysis methodology known as DACUM. Through this study, a profile was developed by consensus and validated for the role of health care chaplain and recommendations begun for revising the current methods for developing curriculum used in Clinical Pastoral Education (CPE) units. A modified DACUM was conducted following the Eastern Kentucky University (EKU) model for DACUM facilitation.

CPE Supervisors could customize the curriculum for their site based on their style and philosophy. There was no standard, accepted curriculum. Based on the ACPE Standards (Appendix A) and current practice there was a reason to question whether students were prepared for the role. The question that arose: was the reason that role-specific courses were not part of a training curriculum because the role was not defined by those in the role? There was a need to thoroughly review the role using a methodology that could be used to develop a profile that lends itself to curriculum development, training delivery, and professional consensus.

The primary conclusion regarding the role of a health care chaplain, coming from this study, is the reason that there is confusion about the role is that those in the role had not been consulted about the duties and tasks performed by a chaplain. A secondary reason why the role of health care chaplain has the tension brought about by two schools of thought is the result of there not being a standard curriculum used in their training.

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ACKNOWLEDGEMENTS

In nomine Patris, et Filii, et Spiritus Sancti. Amen!

There was a time during this study when I wondered if I would ever finish. Thank God for all those who were willing to participate in this journey with me. Thanks is never enough to express one's gratitude. But in this vehicle, it is where my gratitude must start. My wife, my late but ever present parents, my friends and colleagues, you will never know how much you have helped me through this project. Thank you all and know I love you all.

My doctoral committee was always willing to help and suggest improvements in my research and the design of my dissertation. Dr. Steven Downey, my committee chair, was more than patient with me and my endless questions that thanks does not seem adequate. Needless to say, that you have been my Bishop through this and you have my unwavering respect and friendship. Thank you Dr. Herb Fiester my committee researcher, for all of the invaluable feedback you provided me throughout the writing of this paper. In addition, I want to thank Dr. Ellen Wiley, whose thoughtfulness and persistence and humor kept me in the program.

My sincere gratitude extends to the all of the chaplains and CPE supervisors who helped me through participation or guidance during this study. I would like to name them all as they have requested but due to the constraints of the Institutional Review Board (IRB) allow me to just say that this study could not have been possible without you.

Special appreciation is extended to George Handzo my life long mentor and friend, to David Fleenor for his assistance with organizing the panels, to Eric Hall and the staff of HCCN for their assistance in this research, and to Dr. Lai Orenduff and Dr. Richard Schmertzing for their professional friendship. I would also like to express my gratitude to Karen Russell from the Facilitation Center at EKU and Dr. Bob Norton from OSU for sharing their knowledge of DACUM with me in-person, by phone and by email.

> Last but not least, in the words of chaplain C4 who closed the first panel praying:
> With God's name the merciful benefactor the merciful redeemer dear God we thank you for allowing us to be here today for this wonderful opportunity to establish a curriculum for our discipline… Take care of us and provide us with the best going forward in our discipline…
>
> This we pray. Amen.
>
> Facilitator: And all God's children said AMEN!

DEDICATION

This is for my mom and dad, and Sharon.

Mom and dad, you were with me during the many years I worked toward ordination, during Seminary, CPE and all the Call Interviews. God in God's wisdom called me to be your son and you to be my parents. For that and that alone I will be ever grateful to God. You were both called home, but your presence is surely felt and only you know how much I miss you. I miss our many conversations and all the guidance you provided to my many questions. This study reflects what you taught me about education, caring, and respect.

Sharon, this is also for you. Your encouragement, your love, and your support for me and my dreams are the reason I have been able to complete this program and come full circle with my career. This is for you Sharon. I love you.

To paraphrase Father Henri Nouwen (1980) in his work "In Memoriam," you three represented a reality of goodness and safety, which was much larger than you. When, even in the midst of turmoil and restlessness, conflicts and failures, I continued to feel that life is ultimately good and benign. I knew that you had been, and still were, my teachers.

Chapter I

INTRODUCTION

Overview

De Vries, Berlinger and Cadge (2008) clearly articulate a common understanding of health care chaplains. "Chaplains offer a supportive presence that serves to remind patients and caregivers that people are more than just their medical conditions or their current collection of concerns" (de Vries, Berlinger, & Cadge, 2008, p. 23). A chaplain's focus is different than a medical professionals. A medical professional will laser in on a patient's medical condition while a chaplain will seek to assess the whole person, asking people what their lives are like apart from the hospital. They go on to discuss this dichotomy in the changing landscape of health care with the focus being on quality improvement (QI). According to these researchers,

> If chaplains wish to be recognized as a health care profession, they need to be able to describe, to themselves and to others, what constitutes "quality" in their area of patient care…The work that chaplains do is difficult to measure in conventional QI terms: the precise duties of their job are unspecified, and chaplains often find themselves improvising to meet the needs of patients and caregivers. In this situation, how can chaplains define their role in improving health care? … What is the nature of the health care service that chaplains provide, and how is it relevant to patients' health care needs and their treatment? …It is difficult for chaplains to see themselves as a 'professionalizing profession,' and to make the

special nature of their work understood to the administrators who must make decisions about investing in services that have no reimbursement code (de Vries, Berlinger, & Cadge, 2008, p. 24).

Jankowski, Handzo, and Flannelly (2011) reinforce this position when they say, "research to date is inconclusive on what chaplains do that is unique to chaplaincy practice...More research is needed to describe the unique contributions of chaplains to spiritual care and identify best chaplaincy practices…" (p. 117).

Shook and Fojut (2004) in their review of the Catholic Health Initiatives (CHI) 2001 study of chaplain performance and productivity quote Fr. Broccolo of CHI who said, "we saw that many chaplains have a difficult time articulating what they do, which makes it very difficult for other health care professionals to understand their role" (p. 38).

How can you design and develop a curriculum with targeted objectives and associated assessment items for a profession, if members of the profession cannot articulate what they do? You would not know what those in a role do; what the veteran workers need to learn, what new workers need to learn. Targeted role-based curriculum development and delivery is difficult to achieve if members of a profession do not have a clear and consistent picture of a role's primary duties and tasks, knowledge, skills, and traits. Fortuna (1996) made this point in her analysis of the medical administrative assistant role in South Florida. When a profession deems an employee competent, the curriculum development, training, and assessments must all be synchronized and stand on a foundation of a role's duties and tasks to garner employer and customer confidence in one's skills, abilities and aptitudes. "A systematic approach to curriculum design is imperative" (Fortuna, 1996, p. 12).

I conducted a mixed-methods case study with participants who represent a cross-section of health care chaplains from the Metro New York area. One central focus of my research was the development of a Developing a Curriculum (DACUM) profile of the role of health care chaplain and the duties, tasks, knowledge, skills, and traits that represent key competencies for success in the role. The research also investigated, from a trainer's perspective and a curriculum developer's perspective, the strengths and weaknesses of the profile, and which aspects of the profile were the easiest and the most difficult to deliver and/or develop into a curriculum. I examined if race, gender, experience, and religious affiliation influence the chaplain's perception of the DACUM method and final profile.

I have selected the DACUM process to explore the role of the health care chaplain. There are personal, practical, and intellectual reasons (Maxwell, 2013) behind this choice.

From a personal perspective, since I was a young child, I have had an interest in hospital chaplaincy to the terminal and geriatric patients. My parents had me late in life, and I saw how hospital chaplains helped them during their many hospital stays. In the Author Disclosure Section of this chapter, I detail additional personal reasons behind this choice.

From a practical perspective, since the role of health care chaplain has mostly anecdotal research (Fitchett & Grossoehme, 2011; Handzo et al., 2008; Jankowski, Handzo, & Flannelly, 2011; Lyndes et al., 2012), there is a definite need to thoroughly review the role using a methodology that can be used to develop a profile that lends itself to curriculum development, institutional understanding, and team building. As Norton

and Moser (2008) say, DACUM is "ideally suited for researching: (1) the competencies and skills that should be addressed in the development of new education and training programs, and (2) the competencies and skills that should be delivered by existing programs" (p. 14). I was interested to see how well DACUM would work with health care chaplains whose role is changing in health care (Mason, 1990).

From an intellectual perspective, this topic is of interest because if a documented profile has not been created and agreed upon by experts in the field, how do we know if the Clinical Pastoral Education training and curriculum is preparing chaplains for their profession. Since we do not have a clearly articulated profile that has been agreed to by a consensus of those in practice, we must ask if the Clinical Pastoral Education (CPE) training and curriculum is preparing chaplains for their profession? A profile developed by a cross-section of experts could provide a foundation to respond to this intellectual concern.

My research was organized around five data sources: an initial panel of health care chaplains, a validation panel of health care chaplains, a panel of Clinical Pastoral Supervisors who train chaplains, a curriculum development team, and a second validation panel made up of chaplains from the five major regions of the U.S. Each provided valuable data that addressed the research questions that are key to this study.

Statement of the Problem

The core problem addressed in this research was the need for a systematic articulation of a health care chaplains' competencies, or the duties, tasks, and responsibilities. To date, the role of health care chaplain had mostly anecdotal research

(Fitchett & Grossoehme, 2011; Handzo et al., 2008; Jankowski, Handzo, & Flannelly, 2011; Lyndes et al., 2012) that led to confusion across the profession.

CPE Supervisors could customize the curriculum for their site based on their style and philosophy. There was no standard, accepted curriculum. Since CPE was the training ground for health care chaplains, students should be exposed to a curriculum and transformative experiences that adequately prepare them for the role. Based on the Association of Clinical Pastoral Education (ACPE) Standards (Appendix A) and current practice there was a reason to question whether students were prepared for the role. The question arose, was the reason that role- specific courses were not part of a training curriculum because the role was not defined by those in the role?

There was a need to thoroughly review the role using a methodology that could be used to develop a profile that lends itself to curriculum development, training delivery, and professional consensus.

Purpose of the Study

The main purpose of the study was to define the role of a health care chaplain that can be used for training and education and curriculum development and ultimately to impact and reform clinical pastoral education which is currently offered based on site-specific parameters and supervisor specific preferences. A secondary purpose was to discover if a systematic occupational analysis method, such as DACUM, would provide a profile that a cross-section of hospital chaplains would agree accurately represents what they do, and what those who aspire to be chaplains need to know to be successful. The literature showed that DACUM had been done in Canada to uncover the competencies for Palliative Care Spiritual Care Providers (Cooper, Aherne, & Pereira, 2010), but

DACUM had not been done in the U.S. on the generic role of health care chaplain. There was a gap in the literature that my research addressed.

Research Questions

In fulfilling this study's purposes, the following questions were addressed:

1. From the perspective of the initial DACUM panel of health care chaplains, what are the competencies, i.e., duties, tasks, knowledge, skills, traits, and tools, identified for the role of health care chaplain?
    a. From the perspective of the initial DACUM panel of health care chaplains, what knowledge, skills, and tasks are identified as new worker training needs, and veteran worker training needs?
    b. From the perspective of the initial DACUM panel of health care chaplains, what are the most satisfactory, successful, and challenging aspects of the DACUM process?
        i. On the initial panel, how does race, gender, experience, and religious affiliation influence the health care chaplains' perception of what is satisfactory, successful and challenging?
2. From the perspective of the validation DACUM panel of health care chaplains, what are the competencies, i.e., duties, tasks, knowledge, skills, traits, and tools, identified for the role of health care chaplain?
    a. From the perspective of the validation DACUM panel of health care chaplains, what knowledge, skills, and tasks are identified as new worker training needs, and veteran worker training needs?

b. From the perspective of the validation DACUM panel of health care chaplains, what are the most satisfactory, successful, and challenging aspects of the DACUM process?

i. On the validation panel, how does race, gender, experience, and religious affiliation influence the health care chaplains' perception of what is satisfactory, successful and challenging?

3. From the perspective of the CPE supervisors, who train chaplains, how well does the final DACUM profile of a health care chaplain meet their needs and expectations?

a. From the perspective of the CPE supervisors, who train chaplains, what are the strengths and weaknesses of the final DACUM profile?

b. From the perspective of the CPE supervisors, who train chaplains, which are going to be the most difficult and the easiest components of the final DACUM profile to address in future training interventions?

i. What challenges do the CPE supervisors anticipate implementing the final DACUM profile into future training interventions?

4. From the perspective of the curriculum development panel, how well does the final DACUM profile of a health care chaplain meet their needs and expectations?

a. From the perspective of the curriculum development panel, what are the strengths and weaknesses of the final DACUM profile?

b. From the perspective of the curriculum development panel, which are going to be the most difficult and the easiest components of the final DACUM profile to implement into a future curriculum?
    i. What challenges does the curriculum development panel anticipate implementing the final DACUM profile into a future curriculum?

Significance of the Study

This research will benefit the profession of health care chaplaincy in this ever-changing health care landscape in the U.S. One of the potential benefits of this study was the analysis of the role using a time-tested, research-based method, namely DACUM, which has been used worldwide as a foundation for the development of curriculum, organizational development, and occupational profiles. Though this study was focusing on health care chaplains in the New York Tri-State area, if the process and final profile are deemed beneficial to the profession, other geographic regions may opt to have a profile completed on health care chaplains. This would help to build a complete picture of health care chaplaincy.

Furthermore, since health care chaplains are certified, based on denominational/religious affiliation, the findings of this study could impact the certification roadmaps published for chaplains by the major certifying organizations: the Association of Professional Chaplains (APC), the National Association of Catholic Chaplains (NACC), the Neshama Association of Jewish Chaplains (NAJC), and the Association of Clinical Pastoral Education (ACPE).

In addition, the HealthCare Chaplaincy Network has entered into a partnership with California State University Institute for Palliative Care to develop and deliver a Palliative Care Chaplaincy Specialty Certificate. The data from this research may provide a foundation for future curriculum initiatives in their partnership.

Author Disclosure

This research project was conceived during the summer of 2013 while researching and writing my comprehensive exams. When I envisioned the topic for this research project, it was clear that I would have to address some questions and concerns of potential bias, and most of all I would have to be transparent. The questions that have surfaced are:

- Why am I, a student of Valdosta State University in the College of Education and Human Services, exploring a role like health care chaplain?
- Why am I using DACUM?
- Why am I exploring health care chaplains in the metro New York City area? Why am I not working with chaplains in South Georgia?
- Why am I working with the HealthCare Chaplaincy Network in New York City?

A brief review of some key life experiences would help to define the personal reasons (Maxwell, 2013) behind the research topic I chose and provide clarity to some of these questions.

My career goal, from the time I could remember, was to find a way to combine my interest in medicine and the ordained ministry in the church. As a result of having me late in life, I had the opportunity as a child to experience, through my parent's eyes, what

it was like to be an older patient in a hospital venue. This, along with my parent's strong advocacy for higher education, shaped my career goals from early childhood. I set out to become a physician. I was accepted as an alternate, at a new medical school in Eastern Virginia in the mid-1970s. I did not receive full acceptance because preference was given to Virginia residents, and I was born and raised in New York. In 1978, I made a decision to pursue the other half of my career goal, go into ministry. I was admitted to Union Theological Seminary in N.Y.C. as a Lutheran student. Despite the fact that I was attending a pre-eminent school of theology, I had to get permission from my bishop to attend since I opted not to attend a Lutheran Seminary. I received my bishop's blessing and approval. My stated goal for going to seminary was to get ordained and work towards becoming a full-time hospital chaplain. During my days at Union, I did a year of fieldwork as a student chaplain at Lenox Hill Hospital working in General Medicine and focusing on geriatric patients. I loved it. I loved working with the patients, staff, and families.

My next step was to take a unit of Clinical Pastoral Education (CPE). I applied for the unit, was interviewed by the Rev. Joan Hemenway, of The Hospital Chaplaincy, Inc., and was accepted for Summer 1980. One of my CPE supervisors for the Summer Unit was the Rev. Jim Jeffrey, the founder of The Hospital Chaplaincy, Inc. My unit was spent on two floors of The New York Hospital focusing on General Medicine and on the Lung and Breast Cancer floor of Memorial Sloan-Kettering Cancer Center. It was 11 weeks of the most intense, emotional, and uplifting work, I have ever done.

During the first week of the unit, during our orientation, I was introduced to the Rev. George Handzo, a Lutheran Chaplain at Memorial Sloan Kettering Cancer Center

whose focus at that time was Pediatric Oncology. George became my mentor during the unit and a lifelong friend. Rev. Handzo, is now the Director of Health Services, Research, and Quality for the HealthCare Chaplaincy Network (HCCN), which is the latest evolution of The Hospital Chaplaincy, Inc. Rev. Handzo was also the contact who I pitched the idea for this project to initially. I did not know that Rev. Handzo was a globally recognized researcher in health care chaplaincy. I just knew him as George, a tremendous friend and chaplain to me and my parents. When I contacted Rev. Handzo to explore the topic for this research, I had just found three of his many journal articles exploring the role of health care chaplains. I thought he would tell me to explore it in South Georgia, but instead, he said the HealthCare Chaplaincy Network might be interested. I prepared an executive summary for HCCN's new chief executive officer and it was accepted. Rev. Handzo put me in touch with HCCN's newly appointed Senior Director of Chaplaincy Services and Clinical Education, Rev. David Fleenor, who would be my contact for the research going forward.

I graduated from seminary with the Master in Divinity degree, did my internship at six local parishes in Queens, N.Y., where I focused on youth ministry and sick and shut-in visitations, and a year later was certified for a call and ordination by The Association of Evangelical Lutheran Churches (AELC). That was 1983. At that time in history, three synods of the Lutheran Church were in discussion over merging. One of those synods was the AELC. That made getting a call to a parish, which was a prerequisite to becoming a chaplain, very difficult. Everyone was holding pat until the merger in 1988. Those of us certified for call and ordination were promised we would be grandfathered into the new synodical structure. We were not. I was told by one of the

newly appointed bishops, that I would have to redo seminary. I refused, and I changed careers. I relocated with my parents to the North Florida, South Georgia area where I decided that the closest thing to preaching was teaching, a historically recognized ministry.

I went into education. First, I taught high school chemistry and physics for 6 years and then developed the first integrated technology network for a district in North Florida. After 8 years in public education, I went independent as a Certified Technical Trainer, servicing clients all over the eastern United States. I also was heavily involved in curriculum development for in-person technical education and virtual technical education. My clients were government agencies, as well as corporate training centers. During those 15 years, I authored 50 articles on a variety of technical and career planning topics, edited over 30 information technology (IT) texts, earned over 50 IT certifications, developed the Master of Integrated Networking (MIN) certification, and published three books, one of which was the number one Novell book on Amazon.com for over a year.

A health care IT (HIT) company, where I develop and manage the employee and customer certification program, currently employs me. In developing the certification program, I learned about DACUM from William Coscarelli, Professor Emeritus of Southern Illinois University. Following the introduction to DACUM, and its role, benefits, and purpose I enrolled at Eastern Kentucky University (EKU) for DACUM facilitator training. In the fall of 2011, I became a trained DACUM facilitator at EKU under the tutelage of Karen Russell, Director of the Facilitation Center at EKU. While driving home from EKU, I began a series of phone conversations with Prof. Robert Norton of Ohio State University (OSU), the forerunner of DACUM in the United States.

I have used DACUM in my current role and found it to be both efficient, and cost effective. There are several subtle differences between the way DACUM was presented at OSU and EKU. My preference was to favor the EKU methodology, but I am quite open to most aspects of the OSU methodology. Since becoming a DACUM facilitator, I have led numerous DACUM sessions for my current employer. This included validation sessions and leadership reviews.

After contacting Professor Robert Norton, and Karen Russell, and through searching the literature, I discovered that the role of health care chaplain had never been analyzed using the DACUM process. This along with the HealthCare Chaplaincy Network's interest peaked my resolve to pursue this topic.

During the scoping portion of this research, I was introduced by email to the Registrar and Manager of Programs and Services for the HealthCare Chaplaincy Network, Rev. Amy Strano. I spoke with Amy by phone after our initial introduction and discovered that each CPE supervisor develops their own curriculum for their units. There is no standardized curriculum for the training of chaplains. The HealthCare Chaplaincy Network has a *CPE Core Curriculum* (Appendix B) which Amy shared with me by email. The last lines of the curriculum say the following:

> Note to the student: Your CPE supervisor has a specific syllabus and specific course requirements for your group at the hospital to which you are assigned. Each supervisor's syllabus and curriculum varies and is based on the CPE supervisor's curriculum, style and philosophy of supervision. The syllabus and curriculum that you will be given at the start of your CPE program are site specific (personal communication, July 16, 2013).

This raised a host of intellectual questions about the role of health care chaplain. From a practitioner's view of the world and education, in order to train for a role in a consistent and uniform manner, there must be a clear understanding of what those in the role do on a daily basis. Without a role definition, there would be inconsistency in how chaplains are trained and perceived in the world of health care. Was the training I received in the Summer of 1980 different from those who were trained by other CPE supervisors at HCCN that summer? Was my training better or worse? Did I get a clear picture of what health care chaplains do on a daily basis or not? My only response at this stage is to say I don't know. That is one of my reasons for wanting to conduct this study.

Since I have been removed from ecumenical dialog for over 25 years, been removed from New York for over 25 years, and moved into a different career than I ever dreamed of, bias was minimized. My only long-term contact was Rev. Handzo who has removed himself from the study except as an advisor to me and Rev. Fleenor. I worked with Rev. Fleenor on participant selection and augmented his choices using a variety of searches to fill gaps. I could just as easily conduct the study in a different geographical region and may well do so as part of follow-up research. Since I had the close friendship with Rev. Handzo, I trusted his guidance, direction, and interest in the study. I am confident that if this study would be biased in any way HCCN would not have been willing to participate. I believe this study would provide useful information to the profession of health care chaplains.

The only remaining question was what did this study do for me? At 60 plus years old, it brought my career interest full circle. I might not have earned the M.D., or been ordained, but my interest in helping others through the stress of illness has remained to

this day. If I can help document through research, what health care chaplains do, maybe, just maybe I will have done one of the things I was called to do.

In nomine Patris, et Filii, et Spiritus Sancti. Amen!

Conceptual Framework

There are three major concepts that frame this study and address the defined problem. These three concepts are: (a) the profession of health care chaplain and its needs, (b) clinical pastoral education (CPE) and methods used to develop curriculum for CPE, and (c) occupational analysis with an emphasis on the DACUM method.

The first major concept (Figure 1) that informed this study was data available about the role of health care chaplain. Concepts that inform the role and responsibilities of a health care chaplain include: (a) the venues where chaplains practice including community hospitals (Bunniss, Mowat & Snowden, 2013), teaching hospitals (Cadge, Calle & Dillinger, 2011), cancer centers (Balboni et al., 2007), palliative care centers (Cooper, Aherne, & Periera, 2010; Nolan, 2011), trauma centers (Roberts, 2000; Roberts, Wintz, & Handzo, 2012); (b) the perspectives of physicians (Cadge, Calle & Dillinger, 2011; Fitchett et al., 2011), nurses (Wilkes, Cioffi, Fleming, & Lemiere, 2011), health care administrators (Flannelly, Handzo, Weaver & Smith, 2005), patients (Gibbons, 1991; Piderman et al., 2008); and (c) what is currently documented in the literature about what chaplains do, including the Catholic Health Initiatives study (2002), the study conducted by Mowat and Swinton (2007), work done by DeVries, Berlinger, and Cadge (2008), the New York Chaplaincy Study (Handzo, Flannelly, Murphy et al., 2008); and (d) the current trends in chaplaincy with the drive toward research-based chaplaincy

(Brown, 2010; Fitchett, 2002; Fitchett & Grossoehme, 2011; Fitchett, Tartaglia, Dodd-McCue, & Murphy, 2012; Grossoehme, 2011; VandeCreek, Bender, & Jordan, 1994).

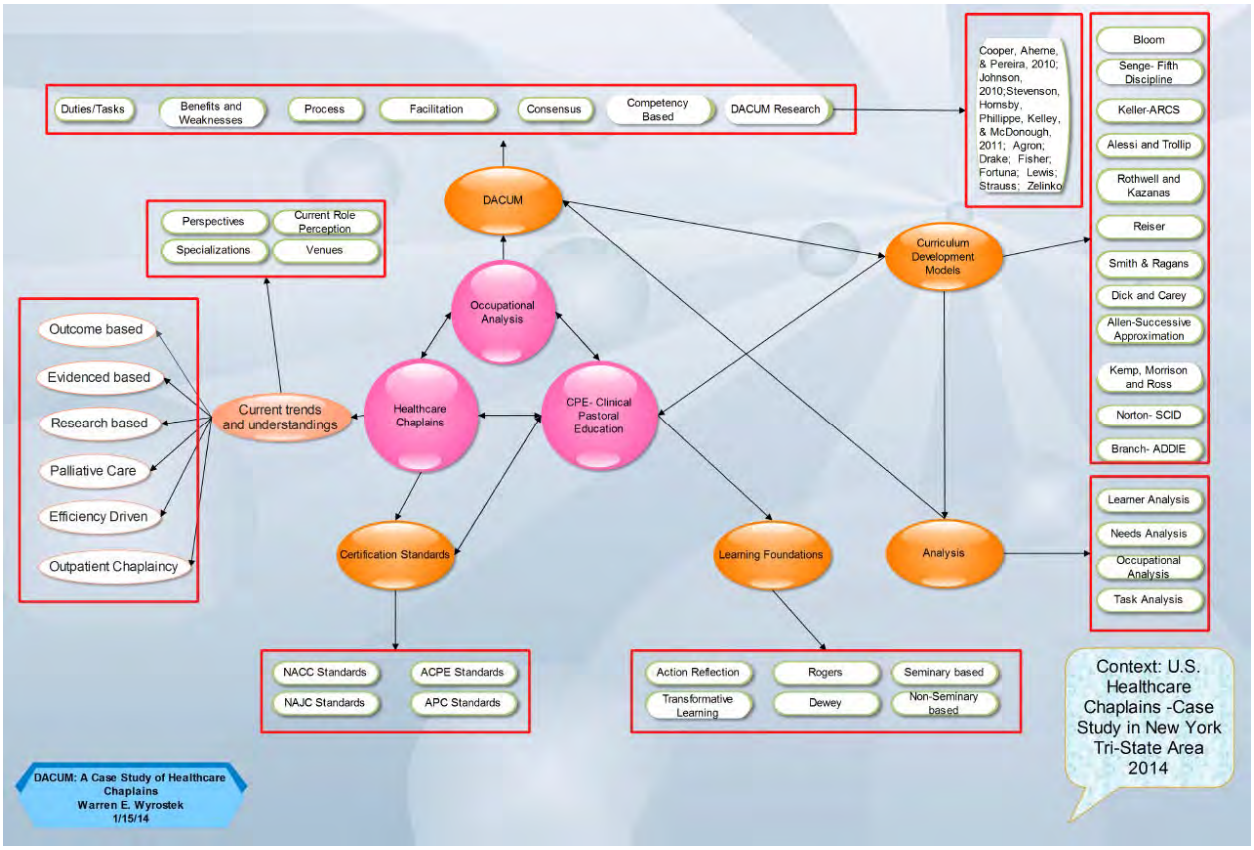

Figure 1. Concept Map Showing Three Major Concepts: Health Care Chaplains, CPE-Clinical Pastoral Education and Occupational Analysis.

The second major concept that informed this study and the concept of health care chaplain was CPE. CPE was the method traditionally used to deliver the training to those interested in health care chaplaincy. CPE also prepares students for certification as a health care chaplain. The certification process was governed in the U.S. by one of four bodies:

1. the Association of Professional Chaplains which administers the BCC (Board Certified Chaplain) credential;

2. the National Association of Catholic Chaplains which certifies Catholic health care chaplains;
3. the Neshama Association of Jewish Chaplains which certifies Jewish health care chaplains;
4. the Association of Clinical Pastoral Education which administers the certification for CPE supervisor- those who train other chaplains.

A fundamental tenet of CPE was the school of thought upon which CPE was practiced. Hemenway (2005) describes this school of thought when she says, "The CPE educational methodology is based on an action-reflection-action model of learning" (p. 323). CPE is also informed by Rogers, and Dewey (Hall, 1992; Hemenway 1996, 2005) and transformative learning (Jones, 2010; Mezirow, 1997, 2003).

The third major concept was a form of occupational analysis, the DACUM method, a functional competency model (Jin Gu, Yongho, & Gi Hun, 2010). DACUM addresses what students in an identified role should be taught (Norton & Moser, 2008), and should learn (Dennison, 1995). DACUM is informed by concepts such as facilitation (Norton & Moser, 2008; Schwarz, 2002), consensus building (Hartnett, 2011; Norton & Moser, 2008), and competency-based education (Norton, 2009). Curriculum development, of which there are many published models, is informed by the profile that DACUM delivers and helps to inform the DACUM process so that the needed data is gathered during the initial panel and validation panels. Some of the systematic models that could be leveraged in the development of curriculum for health care chaplains, using the data from a DACUM analysis, include: (a) the five levels of ADDIE (Allen, 2012; Branch, 2009; Gagné, Wager, Golas, & Keller, 2005; Hodell, 1999; Molenda, 2003); (b)

SCID-Systematic Curriculum Instructional Development, which was modeled on ADDIE and has five phases and 23 components/steps (Norton & Moser, 2007, 2008); and (c) Michael Allen's three-phase iterative successive approximation model (Allen, 2003, 2012).

Associated with the Curriculum Development concept was an ancillary concept of Analysis which includes the concepts of task analysis (Middleton, 1981; Norton & Moser, 2007), learner analysis (Brown & Green, 2011), needs analysis (Witlin & Altschuld, 1995), and finally occupational analysis (Adams, 1974; Norton & Moser, 2008). The DACUM occupational analysis and the curriculum development models helped to inform the concept of CPE.

Summary of Methodology

A mixed methods case study approach, with an emphasis on qualitative methods, was selected for this study. The reason was that the selected approach was well suited for exploring unique cases that have little or no research associated with them such as the case with the role of health care chaplain (Creswell & Plano Clark, 2011; Fetters, Curry, & Creswell, 2013).

I examined one cross-section of chaplains in the metropolitan New York area, affiliated with one organization, The HealthCare Chaplaincy Network, which collaborates with a number of health care institutions in the New York City area and several cities across the U.S. To ensure greater accuracy two panels reached consensus on a profile that represented what health care chaplains do and need to know to function successfully in health care settings today. In addition, I assessed if a panel of curriculum experts and a panel of Clinical Pastoral Supervisors who train chaplains can use the

profile to develop curriculum and deliver training for future learning interventions. Finally, the profile was distributed to a panel of 10 chaplains who were stationed within the five geographic regions of the United States, two per region, to assess if the profile developed in New York City translated well to their current locations.

The research generated some basic quantitative statistics, in addition to qualitative data primarily from DACUM focus groups (panels), semi-structured interviews, and surveys. For the purpose of this study, the term focus group and panel was synonymous.

For this study, five panels were convened and considered as data sources. These five panels were (a) Panel 1 - an initial DACUM panel, (b) Panel 2 - a validation DACUM panel, (c) Panel 3 - a panel of CPE supervisors (trainers), (d) Panel 4 - a panel whose focus was curriculum development, and (e) Panel 5 - a second validation panel made up of chaplains from the five major regions of the U.S.

The initial DACUM panel was the focus of Research Question 1 in this study. The validation panels, Panels 2 and 5, were the focus of Research Question 2. The panel of CPE supervisors was the focus of Research Question 3, and the panel of curriculum experts was the focus of Research Question 4.

I introduce the methodology for this study, in this summary, focusing on the research questions presented earlier. For each research question, I outline my plans for participant sampling, data collection methods, and data analysis.

Research Question 1

The members of the initial panel were purposefully selected using criterion sampling (Patton, 2002). The initial panel was composed of a cross-section of nine experts within the health care chaplain role from the New York Tri-State area who fulfill

the following criteria: have 2 to 5 years or more experience and represent a cross-section of chaplains based on race, gender, and religious affiliation. The nine panelists were a balanced representation of men and women, races and ethnicity, and religious affiliations so that the final profile represented what a generic health care chaplain does and needs to know from this geographic region. If I did not have a representative cross-section due to availability, I planned to address the missing demographic(s) on the validation panel. For example, if I could not get a Catholic chaplain for the initial panel, I would work, to include on the validation panel at least one Catholic chaplain. I would also try to identify participants through social media searches, should a gap exist on the initial and validation panels. Based on the nine panelists I had a balanced panel.

The methods of data collection for this panel were (a) surveys, (b) interviews, (c) the DACUM panel, and (d) a prioritization coding exercise performed during the initial panels. Two primary types of surveys were used. The first survey was a demographic survey developed in such a manner to gather data about each participant's race, gender, experience, and religious affiliation. The second survey was administered at the end of each day's session. The panel was asked to complete a short pencil and paper survey to assess the most satisfactory, successful, and challenging aspects of the DACUM process.

Panelists were asked to participate in one-on-one telephone interviews after their panel convenes to document their perceptions, and their satisfaction, successes, and challenges. All interviews were digitally recorded, transcribed, and thematically coded. These interviews were semi-structured following an interview guide similar to the one used by Barrows (1993) in his sociological study of hospital chaplains.

According to Krueger and Casey (2009), "a focus group study is a carefully planned series of discussions designed to obtain perceptions on a defined area of interest in a permissive, non-threatening environment" (p. 2). To address Research Question 1, the first of five focus groups in the form of an initial DACUM panel-Panel 1 was convened. Each participant contributed their perceptions on the role of health care chaplain in a very open, safe environment.

The initial panel was scheduled from 8:30 a.m. to 5:00 p.m. on 3 consecutive days of an agreed upon week. The initial panel went through the 3-day framework where they collectively developed a DACUM profile in the form of a storyboard that detailed the duties and tasks performed by health care chaplains. In addition, as the panel worked through the process they listed the requisite knowledge, skills, traits and tools leveraged by expert health care chaplains.

One of several prioritizing exercises practiced by facilitators trained at EKU on the final day of the panel has the initial panel participants apply colored dots to those tasks, knowledge, and skills that they perceive as being a new worker or veteran worker training needs. Green dots are applied for new worker training needs, and yellow dots are applied for veteran worker training needs.

In addition to surveys, interviews, and the DACUM panel, I maintained a memo journal of facilitator reflections of the panels' demeanor, participation, conflicts, and input. I also memoed all interviews, and interactions I had with participants. These included observational memos and reflective memos. Part of the journaling process were profile notes, which were any notes I made that specifically relate to the developing storyboard profile that the panels developed. These included coding changes, or notes to

clarify what panelists were saying, or notes to provide context. These were a vital data source for this study. In addition to the written journal memos, I created a photo journal of all in-person panel sessions to record profile changes over the course of the panel graphically.

Data analysis was going on at the same time as data collection was occurring. The analysis included reviewing interview transcripts, panel transcripts, observational notes, and journal notes and memos using thematic coding. Analysis of the profile's development using profile notes and a photo journal was a second step in the analysis. This helped to explain which duty bands were representative of all participants, and which duty bands were representative of a subset of participants.

Listening to recorded interviews and reading interview transcripts was one of the first analytical methods used from the outset of this study. Memos and notes were written and initial categories and tentative relationships identified during this initial analysis step. After listening and reading, transcripts and memos were thematically coded and categorized. Links between themes were identified. Survey data was analyzed for basic descriptive statistics from the Likert-type questions while open-ended questions were thematically reviewed and analyzed. The demographic survey data was analyzed using basic descriptive statistics looking at means and frequencies. The data was cross-referenced with the data from the prioritization coding exercises.

Research Question 2

For the second question, Panel 2, a validation panel was convened. It was composed of a cross-section of six experts within the health care chaplain role from the New York Tri-State area. The validation panel was purposefully selected using criterion

sampling (Patton, 2002). The same criterion of race, gender, experience, and religious affiliation as used for the initial panel guided the selection of the validation panel. I limited this panel to five to six participants since this was the accepted minimum for a DACUM panel (Norton & Moser, 2008). This also becomes a workable number since the number of available chaplains was limited within the ranks of The HealthCare Chaplaincy Network. The key to this panel's selection was to fill any demographic gaps experienced in the initial panel while having a representative cross-section of available health care chaplains. This panel met the day following the completion of the initial panel for 6 hours. The profile that resulted was considered a validated profile and was distributed to the members of Panel 5, who were from different geographic regions, for their input.

The methods of data collection for the validation panel-Panel 2, as for the initial panel were (a) surveys, (b) interviews, (c) the DACUM panel, and (d) a prioritization coding exercise performed during the initial panels. Two primary types of surveys were used. The first survey was a demographic survey and the second survey was administered at the end of each day's session to assess the most satisfactory, successful, and challenging aspects of the DACUM process. Panelists were asked to participate in one-on-one telephone interviews after their panel convened to document their perceptions, and their satisfaction, successes, and challenges.

The validation panel of chaplains reviewed the initial panel's profile, as well as their lists of knowledge, skills, traits, and tools. They were asked to suggest changes, additions, and deletions. In addition, they were asked to go through the prioritization exercise for training needs and learning difficulty.

Chaplains from Panel 2 contributed their input during the time they met with me along with follow-up emails and telephone calls, while the Panel 5 chaplains provided their input strictly through the exchange of emails.

Data analysis was going on at the same time as data collection occurring. The analysis included reviewing interview transcripts, panel transcripts, observational notes, and journal notes and memos using thematic coding. Analysis of the profile's development using profile notes and a photo journal was a second step in the analysis. This helped to explain which duty bands were representative of all participants, and which duty bands were representative of a subset of participants and which bands change as a result of the validation panels' input.

Listening to recorded interviews and reading interview transcripts were the first analytical methods used from the outset of this study. Memos and notes were written and initial categories and tentative relationships identified during this initial analysis step. After listening and reading, transcripts and memos were thematically coded and categorized. Links between themes were identified. Survey data was analyzed for basic descriptive statistics from the Likert-type questions while open-ended questions were thematically reviewed and analyzed. The demographic survey data was analyzed using basic descriptive statistics looking at means and frequencies and compared to the data collected from the initial panel. The data was cross-referenced with the data from the prioritization coding exercises.

Research Question 3

The third panel, CPE supervisors (trainers) panel, was composed of four experts who were experienced CPE supervisors and whose job it was to teach student chaplains

using the Clinical Pastoral Education (CPE) model (Hemenway, 2005). Primarily, the criterion sampling (Patton, 2002) technique was used to identify participants. The key criterion was 2 years or more as a CPE supervisor. The final selection was based on the criterion used to identify a representative panel of CPE supervisors. These Supervisors had real-world knowledge of what those in the health care chaplain role do on a day-to-day basis. Ideally, I would like to have had a panel that was composed of a demographic cross-section of CPE supervisors, but there was a limited number of CPE supervisors available.

The purpose of this panel was to evaluate the final profile, passed to them from the initial and validation panels, to comment and provide editorial guidance on whether the profile would impact the training they deliver, and if so how it would impact it. Since this panel's purpose was to evaluate the profile for training delivery, I was open to experienced CPE supervisors who formally were associated with HCCN but are not currently. This included participants from outside the New York City area. This panel met the day following the completion of the validation panel for less than 4 hours.

The panel of CPE supervisors, who educate chaplains, met to review the final products provided by the initial panel and validation panel. A full review of the profile, lists, and prioritization results were explained. The panel was then asked whether the final products meet their expectations and needs as trainers. They were asked to identify, from their perception, what are the strengths and weaknesses of the profile. Finally, they were asked from their position as an educator, which components of the final products were the easiest and the most difficult to implement in a training intervention, and what challenges did they anticipate in implementing this data into their training routines. They

were asked to go through the Prioritization Coding exercise and apply dots to those tasks that they consider difficult to teach. Notes were taken during this panel, and the discussion was recorded, transcribed, and thematically coded.

Data analysis was going on at the same time as data collection was occurring and included the same steps as used for the validation panel's data.

Research Question 4

Panel 4, the curriculum development panel, was made up of CPE supervisors who were experts in the field of CPE curriculum design and development and addressed Research Question 4. This panel was made up of three participants. The purpose of this panel was to evaluate the final profile, passed to them from Panels 1, 2, and 3, the initial and validation panels, and the CPE supervisor panel. They were asked to comment and provide editorial guidance on whether the profile would be a viable source for the design and development of future curriculum offerings for health care chaplains. This panel was conducted as a virtual focus group several weeks after the profile was digitized and distributed to the members of this panel. Primarily, the criterion sampling technique (Patton, 2002) was used to identify panelists with the most important criteria being knowledge, education, and/or experience in the design and development of curriculum.

The data from the initial, validation and CPE supervisor panels was translated to a digital format and distributed to all panelists. It was also distributed to the curriculum development team. A 2-week period was allowed for review, and then the curriculum development team was asked to meet via web conference for a 2 hour panel meeting to discuss the final products from a curriculum developer's perspective. A full review of the profile, lists, and prioritization results were explained and questions answered. The

team was asked whether the final products meet their expectations and needs as curriculum developers. They were asked from their perception what are the strengths and weaknesses of the profile. Finally, they were asked from their position as a curriculum developer, which components of the final products would be the easiest and the most difficult to implement in a future curriculum, as well as what challenges did they anticipate in implementing this data into a new curriculum. Notes were taken during this meeting, and the discussion was recorded, transcribed, and thematically coded.

Data analysis was going on at the same time as data collection was occurring. The analysis included reviewing interview transcripts, panel transcripts, and journal notes and memos using thematic coding.

Limitations and Assumptions

The methods considered for this study have certain limitations that may influence the results and conclusions. These include the following four constraints. (a) The findings of this study may not be equally applicable and generalizable to chaplains in other geographic regions. Since this was a focused case study of one group of chaplains in primarily a major metropolitan setting, some duties and tasks, i.e., competencies, may be overlooked or included that are not applicable to those serving smaller communities. (b) The findings of this study may not be equally applicable and generalizable to chaplains of all religious affiliations. The chaplains in the New York area are tasked with being both true to their religious heritage and at the same time interfaith chaplains because of the diverse culture present in the New York area. This is unlike hospital chaplains who are affiliated with a hospital that has a religious heritage and a culture that is relatively uniform. The final profile may be more representative of health care

chaplains in a culturally diverse, urban area. (c) Since the panels consisted of no more than 12 panelists each, the findings of this study may not allow one to generalize whether race, gender, or experience influence the health care chaplains' perception of what was satisfactory, successful and challenging before, during and after the DACUM sessions. (d) Since the panels consisted of no more than 12 panelists each from a limited geographic region, the findings of this study may not allow one to generalize whether the final profile has value for learning interventions and curriculum development initiatives in other regions.

The following assumptions were made in conducting this study: (a) The health care chaplains invited to participate were experts in the field and represented a cross-section of health care chaplains; (b) the Eastern Kentucky University approach for leveraging DACUM was suitable for analyzing the role of health care chaplain; (c) a validation panel of five to six chaplains and five to six CPE supervisors who train chaplains was able to assess the validity of the profile developed during the initial profile; (d) race, gender, experience, and religious affiliation may influence the health care chaplains' perception of what was satisfactory, successful and challenging before, during and after the DACUM sessions; (e) the CPE supervisors were able to articulate their assessment of the final profile by identifying its strengths and weaknesses, the easiest and most difficult components to implement in training interventions and finally any challenges they anticipate in implementing the profile into a training delivery; (f) the curriculum development team were able to articulate their assessment of the final profile by identifying its strengths and weaknesses, the easiest and most difficult components to

implement into a curriculum and finally any challenges they anticipate in implementing the profile into a future curriculum.

Summary

I conducted a mixed-methods case study with participants who represented a cross-section of health care chaplains from the New York Tri-State area. One central focus of my research was the development of a DACUM profile of the role of health care chaplain and the duties, tasks, knowledge, skills, and traits that represent key competencies for success in the role. The research also investigated, from a trainer's perspective and a curriculum developer's perspective, the strengths and weaknesses of the profile, and which aspects of the profile were the easiest and the most difficult to deliver and/or develop into a curriculum. I also examined if race, gender, experience, and religious affiliation influence the chaplain's perception of the DACUM method and final profile.

Definition of Terms

APC: The Association of Professional Chaplains serves chaplains in all types of health and human service settings with a commitment to interfaith ministry and the professional practice of chaplaincy care. The APC website is: (http://www.professionalchaplains.org).

ACPE: The Association of Clinical Pastoral Education's is an education association devoted to enhancing the quality of ministry provided by those who provide spiritual care. This is accomplished by the training methods used in Clinical Pastoral Education. The ACPE website is http://www.acpe.edu.

Activity: An activity is "a series of one or more actions necessary to complete a task" (Norton & Moser, 2008, Appendix C, p. 1).

ADDIE: A popular approach to instructional design based on five steps or actions, one for each letter of the acronym. The five actions are Analyze, Design, Develop, Implement, and Evaluate (Brown & Green, 2011).

BCC: BCC is a certification credential used by chaplains to indicate that they are board certified chaplains (BCC) according to a set of national standards and a code of ethics. The BCCI website is: (http://bcci.professionalchaplains.org/content.asp?pl=25&contentid=25).

CBE: Competency-based education, is "an instructional program that derives its content from verified tasks and bases assessment on student performance...Programs of this type are also sometimes called performance-based education (PBE) and performance-based training (PBT) (Norton & Moser, 2008, Appendix C, p. 1).

Competency: A competency is "a description of the ability one possesses when they are able to perform a given occupational task effectively and efficiently" (Norton & Moser, 2008, Appendix C, p. 1).

Consensus: This is a group process of making decisions collaboratively to reach as much agreement as possible.

CPE: CPE is an educational methodology that merges understanding of psychology with theological knowledge and the processes of how we learn, to prepare seminarians, clergy, and qualified laity for the interfaith and social complexities of the modern world, including those found in health care (Hemenway, 2005).

Criticality: Criticality is a "measure of job tasks that panelists believe to be essential and/or most important components of a job" (EKU Facilitation Center, 2011, p. 147).

DACUM: DACUM is an "acronym for Developing a Curriculum. It is an approach to a job, occupational, process, and conceptual analysis, that involves bringing a panel of expert workers together under the leadership of a trained facilitator. Modified brainstorming techniques are used to specify in detail the duties and tasks that successful workers in their occupation must perform" (Norton & Moser, 2008, Appendix C, p. 2).

Difficulty: A measure of learning difficulty to assess the effort required for a worker to learn to successfully perform a task (Norton & Moser, 2008).

Duty: A duty is a "general area of competence that successful workers in the occupation must demonstrate or perform on an ongoing basis" (EKU Facilitation Center, 2011, p. 240). It is also a "cluster of related tasks from a broad work area or general area of responsibility (area of competence)" (Norton & Moser, 2008, Appendix C, p. 2).

Enablers: Enablers are "items such as knowledge and skills, tools and equipment, and worker behaviors that are supportive of and essential to task performance" (Norton & Moser, 2008, Appendix C, p. 2).

Facilitation: "Facilitation is the process of helping a group complete a task, solve a problem or come to an agreement to the mutual satisfaction of the participants" (Kelsey & Plumb, 2004, p. 7). In facilitation, "a person…who is substantively neutral and who has no substantive decision-making authority diagnoses and intervenes to help a group improve how it identifies and solves problems and makes decisions, to increase the group's effectiveness" (Schwarz, 2002, Chapter 1, para. 14).

Frequency: Frequency is "a measure of job tasks that panelists believe require the largest time commitments" (EKU Facilitation Center, 2011, p. 187).

HCCN: The HealthCare Chaplaincy Network in New York is a front-runner in the research, education, and practice of spiritual care within health care and palliative care. HCCN provides multi-faith professional chaplaincy services to metro New York health care facilities.

HPIW: An HPIW is a High-Performance Incumbent Worker, or an expert who serves on a DACUM panel.

ISD: Instructional Systems Design was originally an approach to instructional development for the military and industry that promoted mastery of skills and knowledge needed by adults. Based on behavioral psychology, the emphasis of ISD is the definition of behavioral objectives, learning task analysis, and "teaching to specific levels of learner performance" (Alessi & Trollip, 2001, p. 18).

Knowledge: Knowledge is "an understanding and familiarity with facts and information" (EKU Facilitation Center, 2011, p. 182).

NACC: The National Association of Catholic Chaplains advocates for the profession of spiritual care and educates, certifies, and supports chaplains, clinical pastoral educators, and all members who continue the healing ministry of Jesus in the name of the Church" (http://www.nacc.org/aboutnacc/default.aspx).

NAJC: The Neshama Association of Jewish Chaplains "is the professional organization of Jewish chaplains worldwide." The NAJC "is the address for Jewish chaplaincy expertise promoting the highest standards of training, certification, and delivery of care" (http://www.najc.org/about/mission).

SCID: SCID is an acronym for Systematic Curriculum and Instructional Design. It is the curriculum development framework used by the Center on Education and Training for Employment (CETE) at Ohio State University. SCID is based on the ADDIE model and is part of a nine-step process that is a continuation of a DACUM analysis. SCID ensures delivery of education and training based on actual learner needs (Norton & Moser, 2007).

Skill: A skill is "the ability to perform occupational tasks with a high degree of proficiency" (EKU Facilitation Center, 2011, p. 183) "within a given occupation" (Norton & Moser, 2008, Appendix C. p. 4).

Step: A step is "one of a series of two or more important activities that a worker performs to complete a task" (Norton & Moser, 2008, Appendix C. p. 4).

Task: "A work activity that has a definite beginning and ending, is observable, consists of two or more definite steps and leads to a product, service, or decision" (EKU Facilitation Center, 2011, p. 180). "Tasks are also frequently referred to as the competencies that students or trainees must obtain in order to be successful workers" (Norton & Moser, 2008, Appendix C. p. 5).

Trait: A trait is an "innate or learned ability or distinguishing quality that allows an individual to complete a job" (EKU Facilitation Center, 2011, p. 184).

Training Needs: Training needs are a measure of job tasks, knowledge, and skills, that DACUM panelists believe should be included in a basic, and/or an in-service training program (EKU Facilitation Center, 2011).

Validation: A process used in the DACUM framework designed to prove an occupational profile to be correct, as to appear conclusive. "Generally, an initial panel

followed by one or two validation panels is adequate for the development of a reliable job profile" (EKU Facilitation Center, 2011, p. 230).

Verification: "The process of having experts review and confirm or refute the importance of the task (competency) statements identified through a job or occupational analysis. Other questions such as the degree of task learning difficulty are also frequently asked. This process is also sometimes referred to as validation (Norton & Moser, 2008, Appendix C. p. 5).

Chapter II

LITERATURE REVIEW

Introduction

This brief literature review explores three main concepts that follow the framework described by Norton and Moser (2007). First, I explore the concept of hospital, or health care chaplain and what is currently known about the role from different perspectives. Second, I discuss the concept of CPE, and how chaplains currently are educated. Third, I review the concept of occupational analysis, and how the DACUM process for occupational analysis has been used for roles other than health care chaplains.

Overview

Role-based curriculum development and delivery is impossible to achieve if a profession does not have a clear picture of a role's primary duties and tasks, knowledge, skills and traits (Fortuna, 1996). Fortuna (1996) made this crystal clear in her analysis of the medical administrative assistant role in South Florida. An occupational, or role, analysis has to be conducted for the successful development of role-based curriculum. According to Fortuna, the curriculum development, training, and assessments must all be synchronized and stand on a foundation of a role's duties and tasks to garner employer and customer confidence in one's skills, abilities, and aptitudes. An approach that is systematic to curriculum design is imperative to achieve these goals (Fortuna, 1996).

Norton and Moser (2007) outlined a nine-step methodology that aligns with ADDIE and takes one from needs assessment to competency and program assessment. The second step of this methodology is a job, or occupational analysis, for which they recommend performing a DACUM analysis. DACUM is "ideally suited for researching: (a) the competencies and skills that should be addressed in the development of new education and training programs, and (b) the competencies and skills that should be delivered by existing programs" (Norton & Moser, 2008, p. 14). They further this position by asking whom better to tell you what a worker needs to learn than the expert worker. Therefore, to develop targeted role-based curriculum one must identify the role, perform an occupational analysis, evaluate the current education model, and from that point on begin the process of developing a training curriculum for the role that would either enhance the current curriculum or help to develop new curriculum. For this study, the DACUM process was advocated for the identified role of health care chaplain.

Initially, the sources for this literature review were the Valdosta State University Library Galileo and Academic Search Complete (ASC) database. GALILEO (GeorgiA LIbrary LEarning Online), a program of the University System of Georgia, is an online library portal to authoritative, subscription-only information providing more than 2,000 participating institutions with access to over 100 databases where thousands of periodicals and scholarly journals are indexed. Currently, only educational organizations are eligible to leverage GALILEO. When conducting a search through GALILEO, a DISCOVER search is conducted of most indexed institutional holdings, in this case, holdings of Valdosta State University which span a wide range of databases. GALILEO is a good first attempt at searches but generally only provides limited assistance, as can

be seen in Table 1 where the query results were either too many or too few to be useful. Academic Search Complete is a database, searchable through Galileo that provides coverage of academic journals from multiple disciplines. Seven queries were used to search for the core literature that addresses the concept of a hospital chaplain, CPE, and DACUM. These queries were the following:

- Query 1 = DACUM
- Query 2 = DACUM AND chaplain* AND hospital
- Query 3 = role AND chaplain* AND hospital
- Query 4 = "clinical pastoral education"
- Query 5 = "clinical pastoral education" AND DACUM
- Query 6 = "clinical pastoral education" AND curriculum
- Query 7= "clinical pastoral education" AND hospital AND chaplain*.

The results from these database searches were inconclusive at best, even when limiting the search to peer-reviewed journals from 2001-2014. Since the role I was researching was in the health care field, I modified the search to include the Medline (Medl), CINAHL, and the PsychINFO (Psych) databases. The Medline database is the authoritative data source for subjects in health care and biomedical science. The CINAHL database is the main data source for the nursing field. The PsychINFO database is devoted to literature in the mental health and behavioral science field. These three databases provided a more focused list of studies for this review. Following VandeCreek (1999), and Johnson, Dodd-McCue, Tartaglia, and McDaniel (2013), I conducted the same queries using the ATLA and the ProQuest Religion (Relg) databases and four source journals - *Chaplaincy Today*, the *Journal of Health Care Chaplaincy*, the

Journal of Pastoral Care, and the *Journal of Pastoral Care and Counseling*. The ATLA and ProQuest Religion databases are the primary tools for searching the literature in the fields of religion, theology, biblical studies, and church history. Most of the core literature on chaplaincy was in the ATLA database. Most of the literature that addressed clinical pastoral education was found through the ATLA database and the Medline database searches. The four source journals provided the most targeted instances based on the seven queries conducted. There were some helpful studies on DACUM found in Galileo and Medline. The majority of the studies that used DACUM were found in a search of the ProQuest Dissertations and Thesis database. Ninety-nine studies discussed the concept of DACUM in ProQuest Dissertations and Thesis searches. The results of the seven queries in eight databases are captured in Table 1. Searching through the four source journals alone, I was able to identify 60 peer-reviewed journal articles that addressed the role of health care chaplain. From these seven searches in eight databases and four journals, and following links from cited research studies to some of the major researchers in the field, I have gathered and read over 150 publications related to health care chaplaincy for this review.

In addition to surveying the literature that addressed the three main concepts, I spoke with three of the main researchers in the field of health care chaplaincy by phone and by email. These conversations were conducted to verify my perception of what I was reading and the intended goals of this study. The three researchers were Wendy Cadge, Professor of Sociology at Brandeis University, George Handzo, Director of Health Services, Research and Quality for the HealthCare Chaplaincy Network, and Kevin J. Flannelly, Editor-in-Chief of the Journal of Health Care Chaplaincy. I spoke

Table 1

Results of Seven Literature Search Queries using Eight Databases

Query	ProD	ATLA	Medl	Psych	CINAHL	ASC	Gal	Relg
Q 1	99	0	10	1	6	5	218	0
Q 2	0	0	0	0	0	0	5	0
Q 3	6,539	10	144	40	57	105	26,169	1,070
Q 4	409	141	68	27	25	45	1,788	82
Q 5	0	0	1	0	0	0	1	0
Q 6	267	8	2	27	6	2	323	19
Q 7	301	26	36	2	14	8	998	39

Note: Peer reviewed from 2001 to 2014. ProQuest Dissertations and Thesis (ProDT) queried for the last 10 years. Query 1 = DACUM; Query 2 = DACUM AND chaplain* AND hospital; Query 3 = role AND chaplain* AND hospital; Query 4 = "clinical pastoral education"; Query 5 = "clinical pastoral education" AND DACUM; Query 6 = "clinical pastoral education" AND curriculum; Query 7 = "clinical pastoral education" AND hospital AND chaplain*.

with all three, individually, by telephone and exchanged emails with Cadge. Notes were taken, but transcripts were not recorded. These were semi-formal discussions on the topic of the role of health care chaplain. Comments from these discussions are incorporated with the findings of this review. The questions that I used to frame the conversations are based on my research questions for this study. Not all questions were covered. They simply provided a semi-structured framework for our discussion. The questions, which I shared by email with these researchers prior to our conversation, were the following:

- What is your current role? What is/are your current research interest(s)?
- Why did you get involved in chaplaincy research?
- In your research of health care chaplaincy, what three things have you found that stand out? What has been the biggest surprise?
- Based on your research and experience is the role of health care chaplain well defined? Please elaborate on your answer.
- Based on your current research, would you share with me your perceptions of the role of a health care chaplain? What do chaplains do?
- Based on race, gender, religious affiliation, experience have you found any differences in the way the role is perceived by chaplains? Are these areas worth studying? Why?
- From your research, what do chaplains need to know? What should they be taught in preparation for the role?
- Is CPE doing a good job of preparing students for the role? What are the hits and misses?
- Based on your research, is the certification process aligned with what the role does? Please explain.
- Is the education provided by seminaries and non-seminaries aligned with what the role does?
- As you see it, what is working and where are the deficiencies or gaps in the education of health care chaplains?
- Are there any other topics that you would like to comment on?
- Who are key researchers in the field? Key organizations?

Now that I have discussed the plan I followed for conducting this review of the literature. I next explore the first concept that frames my study, namely the role of health care chaplain and what is currently known about the role.

The Role of the Health Care Chaplain

The role of the health care chaplain is changing from what it was historically and depending on whom you ask or how you interact with a hospital chaplain will color your understanding of the role of the chaplain (Mowat & Swinton, 2007). In order to explore this changing role, I examine the role based on perspective, including palliative care, and some of the current trends.

In order to level-set an understanding of the role of health care chaplain, I need first to explore the traditional understanding of the role. Per Mowat and Swinton (2007), a chaplain traditionally represents a community of faith and works in a setting that is specific. In Scotland, this is the way hospital chaplaincy developed. The chaplain provides pastoral services within an institution, agency, organization, or entity. The services may include worship, ministry to those in crisis, sacraments, counseling, support for the staff and community. Ryan (1997) describes the role of chaplains as helping people, no matter their life circumstance, to be whole persons.

De Vries, Berlinger and Cadge (2008) clearly articulate a common understanding of health care chaplains. "Chaplains offer a supportive presence that serves to remind patients and caregivers that people are more than just their medical conditions or their current collection of concerns" (de Vries, Berlinger & Cadge, 2008, p. 23). A chaplain's focus is to read the whole person, asking questions about peoples' lives outside the hospital. Thompson (2009) describes chaplains as clergy who are specially qualified and

are associated with a secular workplace such as a hospital, military base, or a prison. In the consensus report of the five largest health care organizations edited by VandeCreek and Burton (2001), they systematically describe the role and importance of professional chaplains in health care. Professional health care chaplains use spiritual resources to help patients effectively cope with their situations. They have specialized education, and a growing number are from non-White, non-Christian faith traditions. They list 10 functions, or categories, for the role. They break these categories down into tasks that a health care chaplain performs. According to these researchers, there are minimally 48 tasks or services that a health care chaplain performs (Cadge, 2012). The 10 categories listed by VandeCreek and Burton (2001) are:

- Chaplains provide a reminder of the power of religious faith.
- Professional chaplains reach across faith traditions and do not proselytize.
- Chaplains provide spiritual care through empathetic listening.
- Chaplains are members of patient care teams.
- Professional chaplains lead worship and ceremonies based on ritual.
- Professional chaplains participate in health care ethics programs.
- Professional chaplains train those on health care teams and in the community on the relationship of religious and spiritual matters to the services provided by the institution.
- Professional chaplains act as a mediator, or reconciler, or advocate for those engaged in the health care system.
- Professional chaplains serve as the contact for assessing complementary therapies.

- Professional chaplains support research activities to evaluate the effectiveness of spiritual care (VandeCreek & Burton, 2001).

Despite this understanding of the role of a health care chaplain, the role needed further research and definition (Jankowski, Handzo, & Flannely, 2011). They acknowledge that the research to date is inadequate in defining what chaplains do that is unique to the practice of chaplaincy. Berlinger (2008) in describing professionalizing hospital chaplains, says that chaplains have a difficult time articulating what they do. This is problematic in the day of the outcome-based initiatives in health care institutions. Norwood's (2006) outstanding expose on the ambivalent chaplain describes the problems that we all face in understanding the current role. The role of hospital chaplain is at a crossroads between structural differences that worship medical forms of power and those of the religious order. According to Norwood, chaplains are bridging the medical space and the space of religion, alternately embracing one space or the other. This has caused an ambivalence in the profession and in understanding the role. Shook and Fojut (2004) in their review of the Catholic Health Initiatives (CHI) 2001 study of chaplain performance and productivity quote Fr. Broccolo of CHI who said, "we saw that many chaplains have a difficult time articulating what they do, which makes it very difficult for other health care professionals to understand their role" (p. 38). He goes on to say "chaplains are intuitive and not naturally measurement oriented" (p. 40). Some of the chaplaincy competencies included in the CHI report (Catholic Health Initiatives, 2002) were systems management for holistic patient and staff outcomes, care coordination, direct caregiving skills, ability to conduct a patient assessment, ability to network with the community, and the ability to interact with sensitivity to religious and cultural

diversity. The CHI report clearly stated that there was a "widespread lack of clarity and consistency in understanding, articulating and measuring what chaplains do" (p. 10). One of the key recommendations of this detailed analysis was to "create a template or framework that defines the levels of task complexity for each of the five to 10 key activities of chaplains" (p. 14). When asked by email if the role was well defined, W. Cadge (personal communication, January 23, 2014) said,

> Among leaders, yes; among the rank and file, much less so. In response to the question what chaplains do, Cadge continued, Some are very professional - part of health care teams, sophisticated thinkers good at looking at the whole picture and supporting patients and families where they are. Others just provide rituals on a limited basis.

If this lack of consensus is accurate, I needed to explore the perspective of others. How do doctors, hospital administrators, nurses, patients, and employers perceive the role of health care or hospital chaplain?

How Others Perceive the Role of Health Care Chaplain

Fitchett, Rasinski, Cadge, and Curlin (2009) conducted a national survey of physicians' experiences with chaplains. They found 89% of physicians surveyed had experience with chaplains and 90% of those were satisfied or very satisfied with the professional chaplains they had interacted with. The factors cited for the level of satisfaction included practice context, beliefs about when it is appropriate to pray with patients, religion and spirituality training, and observations of the effects of religion and spirituality on a patient. Knowing what chaplains do had a positive impact on the physician's perspective.

Vanderwerker et al., (2008) explored the data available in the New York Chaplaincy Study focusing on chaplaincy referrals. They go on to say that the medical community and the population at large miss many opportunities to engage chaplains in the care of patients because of a misunderstanding or underestimation of capabilities of chaplains. This research into the source of referrals is a real eye opener when it comes to who will engage a chaplain, when that will happen and where it will. This speaks to the role of the chaplain and the training for medical staff and chaplains. They found in their analysis that patients are referred to chaplains for many reasons that do not include religious or spiritual. Over half of the referrals were for relationship, support or emotional issues. About a third of the referrals came from physicians and social workers for the same reason implying that their view of a chaplain's role is limited. Vanderwerker et al. found that primarily referrals to chaplains come from nurses and patients, with comparatively few referrals coming from social workers or physicians.

From the patients' point of view, two studies stand out. Balboni et al., (2007) examined factors associated with an advanced cancer patient and caregiver well-being. Patients with an advanced cancer diagnosis and failure of first-line chemotherapy were interviewed. Many patients viewed their medical experience as devoid of spiritual support including that provided by chaplains. Their findings showed support for a patients' spiritual needs was associated with an improved quality of life, QOL. A third finding was that there is an association between a patient's religiousness and their desire to extend life using aggressive measures.

On the other hand, Piderman et al. (2008) showed in a study that patients place a high value on spiritual care and that many desire more. Their results revealed that

"religious readings, rituals, and prayer, as well as the supportive activities involved in the practice of pastoral care, are important to most hospitalized patients. Patients look to chaplains to be 'a reminder of God's care and presence'" (p. 63). Being present in anxious times, listening and caring for friends and family were also noted as important attributes of hospital chaplains from the patients' point of view. Almost half of the respondents were unclear of how to make contact with a chaplain.

Fitchett et al., (2011) demonstrated the ways chaplains function and are perceived within one Pediatric Palliative Care (PPC) health care environment. Most PPC Programs had staff chaplains but with variations on how the chaplains functioned on the teams. Physicians, medical directors, and chaplains all had different ways of describing what the role of the chaplain is in their environments. Based on this variation this has implications for CPE training and the training of chaplains for Palliative Care roles. The variation in the way the role is described provides evidence that inconsistency in the role is widespread and may have its genesis in the standards for training.

Nolan (2011) studied how palliative care chaplains work with patients at the point when it has been decided to cease active treatment, the point where they risk losing hope and falling into despair. Nolan demonstrates a theory of chaplaincy grounded in presence which is a bit foreign to hospital teams as shown in the Fitchett et al. (2011) study. Nolan identified four distinct moments in the "chaplain's being-with their patients, moments through which a chaplain may become a hopeful presence to those with whom they can work" (Nolan, 2011, p. 23). "The four moments are defined as an 'evocative presence,' an 'accompanying presence,' a 'comforting presence,' and a 'hopeful presence'" (pp. 23-

25). Nolan showed using a grounded theory approach that a chaplains' presence can help a patient to have hope in the present.

Wilkes, Cioffi, Fleming, and Lemiere, (2011) found pastoral care in aged care remains ambiguous. The characteristics of pastoral care that emerged were a trusting relationship, spiritual support, emotional support and practical support. They found the role of the pastoral care worker as a spiritual guide, confidante, and emotional and practical supporter acting within a trusting relationship. An essential component of a pastoral care worker's toolset is the ability to inject spirituality through open and reflective listening. This was cited as essential in geriatric health care for forging relationships with patients classified as terminal or requiring palliative care. The researchers also pointed out how pastoral care workers, chaplains, supported the role of nurses and other health care professionals in providing "family-centered care" (Wilkes et al., 2011, p. 220).

Sinclair, Mysak, and Hagen (2009) explored and characterized key components of spiritual care services within an oncology setting. An apparent theme was a need to "determine the role of a chaplain in cultivating the expression of the organizational values" (p. 421). The researchers also found that a need existed for "discovering effective ways for spiritual care providers to best meet the needs of the health care staff" (p. 421).

Flannelly, Galek, Bucchino, Handzo, and Tannenbaum (2005) conducted a national survey of hospital directors of nursing, pastoral care, social services, and medicine examining the various roles of a health care chaplain. Grief and death, prayer, and emotional support were roles that were rated very important to extremely important

by directors in all four disciplines. Conducting religious services or rituals, consultation, and advocacy, and community liaison-outreach were all rated between moderately and very important. Directors in smaller hospitals put less value on the role of the chaplain.

Research: A Current Trend in Health Care Chaplaincy

There is a definite lack of consensus in health care and within the profession of chaplaincy over the role of a health care or hospital chaplain. In the ongoing changes in health care (Mowat & Swinton, 2007) along with the changing role of hospital chaplaincy, there are several current trends that would impact the role and how it would be perceived in health care. The most discussed trend is the notion of becoming a research-based profession (Brown, 2010; Fitchett & Grossoehme, 2011; Grossoehme, 2011). Fitchett (2002) called for the profession of health care chaplaincy to become research informed. He believed that research would strengthen the practice of ministry, elevate the awareness within the profession of what health care chaplains contribute, and help to encourage "interdisciplinary relationships" (p. 68). To help the profession move in the direction of becoming research informed he advocated that the APC should adopt a three-step approach. First, in 5 years all APC board certified chaplains should value research. Second, in 10 years all APC board certified chaplains will become research literate. Finally, in 10 years 2% of APC board certified chaplains will be doing research as part of their role. Nine years later, Fitchett and Grossoehme (2011) said that health care chaplaincy still had a long way to go to becoming a research-informed profession even though there was a significant body of research data that describes what is done by those in the profession. They cite the work of Mowat (2008) who explored the research literature from the U.K. and overseas and said that the research did not "address the issue

of efficacy in health care chaplaincy" (p. 7). Mowat goes on to discuss eight categories that would serve as a starting point for future research. The eight were:

1. Current chaplaincy
2. Evidence and efficacy
3. Definitions of spirituality, religion, and spiritual need
4. Links: relationship of spiritual care / religious care to well-being
5. Patient perspective
6. Multifaith chaplaincy
7. Territory- who does spiritual care
8. Assessment as a core task for chaplaincy

Brown (2010) proposes adopting a case study paradigm for research done by health care chaplains. She moves chaplaincy research from a conceptual orientation to one of practical execution. She describes a method that could assist chaplains learn to conduct case study research.

Common Standards on Professional Chaplaincy

I looked at the role of health care or hospital chaplain through the lens of the chaplain, health care professionals and current trends in the profession. To provide a complete picture, I needed to see what the certifying bodies say about the role of professional chaplain. In 2004, the Council on Collaboration, which is made up of members from the APC, AAPC, ACPE, NACC, NAJC, and CASC, met and developed the Common Standards for Professional Chaplaincy. These standards are made up of four main domains and 29 competencies which candidates must comply with certification. The four domains are:

- Theory of Pastoral Care: for which candidates, must be able to communicate clearly a theology of pastoral care that is aligned with a theory of pastoral practice (plus four other competencies).
- Identity and Conduct: for which candidates, must present themselves in a manner that is respectful to the physical, emotional and spiritual borders of others (plus eight other competencies).
- Pastoral: for which candidates, must demonstrate the ability to establish, deepen, terminate pastoral relationships in a sensitive and respectful manner (plus eight other competencies).
- Professional: for which candidates, must demonstrate the ability to promote the integration of spiritual care into the day-to-day life of the organization in which this service is provided (plus five other competencies).

In a telephone conversation with Handzo (personal communication, February 5, 2014), I asked if the certification process aligned with what the role does? Handzo's response was, "We don't know what the role does so how can it be aligned? The certification process is aligned with the 29 competencies for certification, yes. That alignment is pretty good now, pretty solid…But the issue is do the competencies reflect what the job really requires. That is the question." The lack of clarity over the role's definition is a concern across health care and is a key driver for performing this study.

Next, I explore how health care chaplains are currently educated and examine how it shapes our current understanding of the role. Understanding the instructional process used for training chaplains, and the standards used for assessing competence

helped to inform why there is such a wide range of views of the role of health care chaplain. The second major concept for this study is Clinical Pastoral Education.

Clinical Pastoral Education

CPE is the method traditionally used to deliver the training to those interested in health care chaplaincy. The Association of Clinical Pastoral Education (2010) says, "CPE provides theological and professional education using the clinical method of learning in diverse contexts of ministry" (p. 12). King (2007) describes CPE in broad terms "as teaching students to engage, explore, and learn about their context or setting of ministry" (p. 148). CPE is offered in a variety of organizational settings including hospitals, long-term care facilities, prisons, hospices, rehabilitation centers, and local communities of faith. Hemenway (1982) says the goal of CPE is to "encourage and nurture each student's growth into his or her professional identity and functioning in Christian ministry" (p. 194) while enabling students to grow through practical opportunities into self-knowledge and self-use.

Those who are trained educators for CPE units are said to be certified CPE supervisors (Hemenway,1982). They are ordained members of the clergy or chaplains who are ecclesiastically endorsed by a religious body. The supervisors are trained in psychology, the theories of education, and group dynamics. Hemenway (2005) shares from her years of supervising units of CPE that a typical unit is made up of "weekly teaching seminars with an emphasis on theory combined with student case presentations that emphasize application. A key educational element is the small process group" (p. 323). "A small process group is an open agenda study group placed within a clinically-based educational program (CPE) which employs an action-reflection-action model of

learning as part of professional preparation for ministry" (Hemenway, 1996, p. ix). A group would typically have three to eight participants and would meet three times a week in a full-time unit for an hour and a half per session. A full-time unit consists of 300 hours of clinical time where students, serving as chaplain interns, visit patients, and 100 hours of individual and classroom education. In July 2013, I asked the registrar at HealthCare Chaplaincy Network if they used a standard curriculum for CPE. She sent me by email the core curriculum model for CPE (Appendix B). At the end of the core curriculum is a note to students, which said,

> Your CPE supervisor has a specific syllabus and specific course requirements for your group at the hospital to which you are assigned. Each supervisor's syllabus and curriculum varies and is based on the CPE supervisor's curriculum, style and philosophy of supervision. The syllabus and curriculum that you were given at the start of your CPE program are site specific (personal communication, July 16, 2013).

What Hemenway (1996) defines as typical has a great deal of variety based on the supervisor, site, and the style and philosophy of the supervisor.

Typically, the education is made up of writing verbatims and case studies, instruction, group process work, and one-on-one supervision (Healthcare Chaplaincy Network, n.d.). Verbatims are a pastoral conversation in a written format (Logan, 2006). The verbatim is a tool for student learning and reflection on his or her self as a professional minister and as a person. Verbatims are a tool leveraged throughout a unit of CPE. Some year-long CPE programs, such as the one at the University of Chicago

Medical Center, have included a group-centered research project as part of the curriculum (Gibbons & Myler, 1976).

A study by Jankowski, Vanderwerker, Murphy, Montonye, and Ross (2008) showed that CPE students showed significant increases in their pastoral care skills and emotional intelligence over the course of their CPE training. This study examined "CPE student growth in pastoral skills, emotional intelligence, and self-reflection while controlling for social desirability and other important demographic variables" (p. 135). Some groups of students experienced more improvement than others. When pastoral skills were examined, the researchers found that students with fewer years of professional ministry, no prior CPE experience, and lower scores on a social desirability scale experienced a more positive change in their skills. "The sole significant predictor of improved emotional intelligence and improved self-reflection was participating in an intensive course" (p. 145). This finding contributes to the belief that CPE training had positive impacts on the practice of ministry and contributed to the emotional growth of those who experienced CPE. What this study does not address is if CPE adequately prepares students for the day-to-day role and responsibility of being a health care chaplain.

In order to fully understand CPE, I must next examine CPE from the student's perspective.

Student Experience

Students come to a unit of CPE with different goals and objectives, from different backgrounds and theologies. Those all shape the CPE experience. Understanding CPE from the student's vantage informed this study by explaining why there are such different

views of the role of chaplain. Is the difference due in part to what a student experiences in CPE?

Students entering a unit of CPE for the first time face many challenges, questions and opportunities for growth (McKinney, 2014). McKinney shares the following anecdote from one student who felt that enduring a unit of CPE was less enjoyable that having experienced a root canal without anesthesia. Jones (2010) identifies some of the challenges as "hard encounters with the living human documents in crisis situations, a strange methodology, an unfamiliar curriculum, a difficult group process, and an unsettling process of individual supervision" (p. 1). This is sometimes referred to as a baptism by fire since students are thrust into providing pastoral care without knowing what they need to know about the concept, nor do they have a clear picture of themselves as a pastoral provider (Jones, 2006).

A students' experience in CPE is both difficult and impossible because it is filled with paradoxes (Fitchett, 1983). At a high level, the paradoxes are based on issues of faith, such as being obedient and transform our own lives, while at the same time experiencing the transformation that comes from surrender. Fitchett's (1983) educational theory for CPE addresses four paradoxes that students engaged in CPE experience. These four are the paradoxes of student and professional, independent and dependent learning, learning and growing, and relationship and technique. From the second day of a unit the CPE student is expected to be both a chaplain and a student, be able to define his or her learning goals while at the same time take supervisory instruction, be both a learner of skills while growing as a person and professional dealing with human beings,

and be able to understand if techniques are applicable to a situation or if an interpersonal relationship is key.

Vuono (2010) describes her transformative experience in a CPE unit. It went from exacerbation and exhaustion to wanting to quit after the first week, discomfort with other health care professionals on a hospital floor, to a realization that her classmates no matter how experienced in ministry were also struggling. As the unit continued, Vuono experienced acceptance by the floor staff. Then she had to evaluate her fellow students. Based on her class' review of her work, she came to realize that she had accepted herself. She was on a level footing with her peers. She came to an awareness that she did not have to fix others in order to help them. "Tell me how you feel" (p. 2) is something Vuono learned to look forward to hearing and saying. She also learned, as most CPE students do, that when someone needs help the way to react is by hearing, listening, and getting out of the way.

Steinhoff-Smith (1992) describes how CPE could be a tragic experience for some students. CPE becomes a tragedy because though it is conceptualized as a program to help pastors become more caring and to challenge seminarians to examine how they care for those in need, it can turn into an opportunity for students to be "treated brutally, without care" (p. 53). Steinhoff-Smith attributes this type of outcome to three problems with CPE. They are: "(1) a fusion of supervisory and therapeutic roles in the CPE supervisor, (2) the occurrence of psychological abuse, and (3) incidents of sexual harassment" (Steinhoff-Smith, 1992, p. 47). For Steinhoff-Smith the key to improving CPE is to recognize that the role of the supervisor is not the same as the role of a secular psychotherapist. These two roles must be clearly defined and differentiated, or CPE

students would not benefit from self-examination and personal transformation in this vital part of their ministerial education.

Next, I briefly examine the educational foundations of CPE. Understanding the key philosophical theories behind CPE also informed this study, because the theories helped explain why there are different perceptions of the chaplain's role.

Educational Foundations

CPE is an educational methodology that merges understanding of psychology with theological knowledge and the processes of how we learn, to prepare seminarians, clergy, and qualified laity for the interfaith and social complexities of the modern world, including those found in health care (Hemenway, 2005). Hemenway (1996) in a study of what it is like to be inside the CPE circle says, the "educational methodology in CPE has been inconsistent, causing confusion among ourselves and our students" (p. vii). If there is confusion and inconsistency among CPE supervisors, might this not explain the confusion over the role and responsibility of health care chaplains? Four key influences on CPE are the action-reflection-action model of learning, John Dewey, Carl Rogers, and transformative learning.

"The CPE educational methodology is based on an action-reflection-action model of learning" (Hemenway, 2005, p. 323). Rimanoczy and Turner (2008) list 16 elements that make up the action-reflection-action learning model. These elements include balancing task and learning, guided reflection, one-on-one coaching support, a safe environment, and unfamiliar environments. Little (2010) has a different take on the action-reflection method. He says the action-reflection method is excellent for helping students understand pastoral interactions. However, it does not "facilitate the further

development of the propositional knowledge base" (p. 4). This is limited by the supervisor's practical and propositional knowledge which can in turn limit what the students would learn. The differences in a supervisor's practical and propositional knowledge could definitely explain why one student's experience with CPE is so radically different from another students'. As student's move through units of CPE, it might also shape their personal perception of what chaplains do and need to know.

John Dewey was a proponent of a philosophy of education that focused on the experiential side of learning (King, 2007). Dewey's belief was that the process of how to think was as important as what to think (Hall, 1992). One of John Dewey's contributions to the field of education and specifically action-reflection learning is the emphasis he placed on experience that guides our actions. Experience does not occur in a vacuum (King, 2007). Dewey's position was people make meaning by explaining events and then use those explanations to guide behavior. The explanations are personal interpretations (Rimanoczy & Turner, 2008). The principle of continuity of experience (Dewey, 1938) helps one to realize that all experiences take something from the past while modifying those that come in the future. Fundamentally, Dewey (1938) believed people learn by doing through a full range of experiences. The experience-based, progressive education philosophy promoted by Dewey influenced what has come to be known as clinical pastoral education to such a degree that CPE students are told simply to trust the process. This process is the educational method practiced in CPE. It is an "experiential or process method, as opposed to a method of accumulating facts" (Hall, 1992, p. 3). Since CPE is experiential, and students have different experiences in CPE, this too might help one to understand why there is confusion over the role of health care chaplain.

CPE is also influenced by Carl Rogers and his theory of client-centered therapy (Turner, 2005). Rogers taught that clients have within themselves the solution to their problems and conflicts. The chaplain, or pastor, is to assist a client in accessing the personal resources and effective adjustments. Rogers was not content with simply a client-centered approach. He wanted to broaden its scope from the personal and interpersonal to the wider social order (McClure, 2010). Rogers believed that what was therapeutically learned from individuals has much broader implications. His work on social and cultural matters was also person-centered. McClure (2010) shares some anecdotes from Roger's many works and describes how many of the differences based on class, race, gender, or ethnicity are indistinguishable when a person is discovered. For Rogers closeness is brought between people when their humanness is discovered. In this modern day, this still influences CPE students who are from various faith traditions, classes, genders, cultures and political philosophies especially as they learn about themselves from each other within their group, in one-on-one supervisory sessions, and interacting with patients.

Modern-day CPE is also informed by transformative learning (Jones, 2010; Mezirow, 1997, 2003). Transformative learning is a comprehensive theory of adult learning that addresses the human need "to understand the meaning of our experience" (Mezirow, 1997, p. 5). According to Mezirow, we need to understand what is happening around us. Based on their experiences human beings construct a paradigm that helps them understand their world and their surroundings. We each have a lens through which we see the world and the many experiences we have. This lens helps us develop expectations of how the world works and what experiences mean. In CPE, students are

often caught off-guard and unprepared due to unexpected experiences. The reaction could be one of denial, or rejection, or repression or it could be one of openness to change. If the student is open to change then the student would start a process of critical questioning, and reflection on experiences that were unexpected. According to Jones (2010), "transformative learning is a process in which persons question, examine, validate, and reconstruct their perspective on the world, and the way it works" (Jones, 2010, p. 2). Critical thinking is the key to transformative learning and it "drives the transformation of a person's frame of reference" (Jones, 2010, p. 3). There are 10 phases in transformative learning. The first is experiencing a disorienting dilemma and the tenth is reintegrating into society with a new perspective. In addition, transformative learning has an affective dimension with a rational component and components that recognize grief when change occurs and the emergence of self (Jones, 2010). Jones explains that these are processes that students and supervisors of CPE are familiar with and experience on a daily basis. What should be noted is that many units do not candidly address the process of critical thinking that drives transformation. Just as there is confusion over the role of chaplain, there is confusion over the role of CPE supervisor and what that means from an educational perspective.

I have briefly examined what CPE is, how a student's experience is different based on the supervisor and the educational foundations of CPE. Next, I must briefly review the standards for a unit of CPE. This would help to explain the high-level goals of CPE and how the curriculum is currently designed. I briefly share the CPE standards published by the ACPE for a basic unit of CPE and the Core Curriculum model used by the HealthCare Chaplaincy Network.

Standards, Objectives, Outcomes, and Curriculum

In the 2010 Standards Manual, the Association of Clinical Pastoral Education says a unit of CPE enables pastoral formation, pastoral competence, and pastoral reflection. It defines the objectives and outcomes for a basic, introductory unit of CPE, what is called a Level 1 unit (Appendix A). CPE objectives define the scope of the program curricula, and the outcomes define the competencies to be developed by students as a result of participating in each of the programs.

It is also clear that some, like Cadge (2012) have different opinions on their use and applicability. Cadge (2012) advocates for some additional priorities for the CPE curriculum. She encourages "chaplains to give priority to educational models that include basic courses in health-care administration, counseling, research methods, and substantive topics such as medical ethics-information they need in order to function in increasingly complex health-care organizations" (p. 205). Cadge goes on to advocate for "interdisciplinary programs that enable future chaplains to learn… with and from students and faculty in public health, hospital administration, nursing, and other fields" (p. 206). This would be the best training for future chaplains. To reach these goals, Cadge believes training programs must be housed in universities with outstanding schools of public health, medicine, and divinity so that chaplains are introduced to the interdisciplinary nature of health care and the hospitals before taking CPE. A benefit of this type of program would be the "development of university-based faculty with expertise in hospital chaplaincy" (p. 206).

Next, I explore the third major concept of my study namely occupational analysis. Could an occupational analysis, such as DACUM, help those who interact within health care understand what chaplains do and need to know?

Occupational Analysis

Occupational analysis methods which are comprehensive and systematic are essential to ensure the relevance of an occupational course, in that graduates of the programs, will function competently in the occupation (Willett & Hermann, 1989). Depending on your focus, your perception, or your position in history, the understanding of occupational analysis varies. There is also some debate over the usage of the term occupational analysis and job analysis.

According to Fryklund (1970), an occupational analysis is a technique used to identify and document for instructional purposes the essential components of an occupation, or any part of an occupation or activity. Any occupation could be analyzed for instructional purposes if it has core processes and procedures. Duenk (1993) says an "occupational analysis is a technique used to break down an occupational teaching area into a manageable approach for instructional purposes" (p. 7). Seibert and Mauser (1979) define an occupational analysis as the process of defining an occupation in terms of the functions performed by those engaged in the occupation.

Prien, Goodstein, Goodstein and Gamble (2009) say that a "job analysis is a systematic process for collecting and analyzing information about a job" (p. 11). Bemis, Belenky, and Soder (1983) define job analysis as a "systematic procedure for gathering, documenting, and analyzing information about three basic aspects of a job: job content, job requirements, and the context in which a job is performed" (p. 1). Clark (2008) sees a

job analysis as "a top-down process for defining the knowledge and skills associated with job performance and includes defining job functions, tasks, guidelines or steps, and associated knowledge" (p. 187). For Clark, course development should begin with an analysis of the job. It is lacking in much course development today. For Jonassen, Hannum, and Tessmer (1989) a job analysis' role in instructional development is one of navigation. According to Gael (1983), a job analysis is a process in which a job is broken down into its parts, and the parts are subsequently reviewed to understand the nature of the work. Another way of saying this is a job analysis occurs when a job is broken down into the tasks performed by incumbent workers, and the tasks are then grouped into duties in order to gain data about a job's duties and tasks. A job analysis denotes what people do on the job. A job analysis helps to determine training needs for new and experienced employees. This is a major benefit of conducting a job analysis.

Whether one uses the term occupational analysis or job analysis is based on how the key terms of position, job, and occupation are defined.

Key Terms Used in an Occupational or Job Analysis

The U.S. Department of Labor (DOL) (1982) defined a position as the work activities performed by a worker at a single place of employment. A job is a:

> single position or group of positions, at one establishment, whose major work activities and objectives are similar in terms of worker actions, methodologies, materials, products, and/or worker characteristics; and whose array of work activities differs significantly from those of other positions (p. 5).

They go on to define an occupation as:

> a group of jobs, found at more than one establishment, having work activities that are identical or related in terms of combinations of similar methodologies, materials, products, worker actions, and/or worker characteristics (p. 6).

Based on the DOL definitions of an occupation and a job, the literature cited so far leads me to consider health care chaplains as an occupation because it is a group of jobs found at multiple locations with similar sounding activities. This study confirmed this supposition. The role of health care chaplain might be a job at one institution, but examined across multiple institutions, it was considered an occupation.

Methods of Occupational/Job Analysis

There are numerous ways to conduct an occupational or job analysis. Historically, some of the models used for job analysis include:

> the Department of Labor method, the Functional Job Analysis method, the Critical Incident Technique, the Job Element method, the Position Analysis Questionnaire, the Task Inventory/Comprehensive Occupational Data Analysis Program, the Health Services Mobility Study program method, the Guidelines Oriented Job Analysis method, the Behavioral Consistency method, and the Factor Evaluation System method (Bemis, Belenky, & Soder, 1983, p. 13).

Hartley (1999) expands on this list of approaches to include one-on-one interviewing, behavioral event interviews, phone interviews, surveys, work assessments, DACUM, job analysis worksheets, observations, and procedural reviews. Johnson (2010) in a DACUM comparative study of GIS technicians includes focus groups, work records, information searches, and critical incident evaluations as methods of analyzing a job. According to Johnson, "most methods of job analysis rely on indirect sources of

data while the DACUM method relies directly on the workers themselves to describe and define their jobs" (Johnson, 2010, p. 32).

In Willet and Hermann's (1989) study of three approaches for occupational analysis used to define the competencies required by secondary school teachers, it was found that the Critical Incident method was the least effective in obtaining a list of competencies, while DACUM and Information Search were equally effective. They also found that DACUM combined with Information Search were needed to obtain an adequate list of competencies for secondary school teachers. Based on the metrics of comprehensiveness and uniqueness, DACUM and Information Search each helped to identify 73.4% of 79 competencies while Critical Incident only was able to help identify 32.9% of the competencies. When DACUM and Information Search results were combined, 93.7% of the inventoried competencies from their Phase I study were identified. In summary, Willet and Hermann (1989) concluded that a need was demonstrated for a "comprehensive, systematic occupational analysis before commencing the design of an occupational course" (p. 87). Willet and Hermann then recommended "for any major occupational analysis, at least two techniques be used" (p. 87). For my study, I proposed DACUM and interviews be used.

According to Norton, (1992), the main reason for using DACUM as expressed by educators and trainers is it provides a relevant, up-to-date, data source for curriculum development and for instructional programs. A data source for curriculum development that is maximally based on local business and industry input is needed to ensure that the training provided and developed is aligned with business' expectations and requirements.

According to Norton and Moser (2008), DACUM is quick and inexpensive and beneficial from a public relations perspective. It is a way to show that educational institutions are serious about collaborating with industry in determining what duties and tasks students must be competent in in order to be valuable future employees. "DACUM is the best means of conducting job/occupational analysis that is available" (Norton & Moser, 2008, p. 5).

An Overview of DACUM - A Way to Conduct an Occupational Analysis

Robert Adams describes DACUM as a "single sheet skill profile that serves as both a curriculum plan and an evaluation instrument for occupational training programs. It is graphic in nature, presenting definitions of the skills of an entire occupation" (Adams, 1975, p. 24). Norton expands upon Adam's description of DACUM stating that this system has been "used effectively to conceptualize future jobs and to analyze portions (selected duties) of one's occupations…DACUM also has been used widely as a basis or foundation for analyzing various industrial systems and processes" (Norton & Moser, 2008, p. 2). They go on to say that, one of the major benefits of DACUM is the panel of experts used in the initial panel. These experts, through facilitation, reach a consensus on a role that a wider population of those in the role validate, which helps in gaining buy-in for the profile across the occupation and the subsequent curriculum. DACUM addresses what students in an identified role should be taught (Norton & Moser, 2008), and should learn (Dennison, 1995).

A joint effort of the Experimental Projects Branch, Canada Department of Manpower and Immigration, and General Learning Corporation led to the creation of DACUM (Finch & Crunkilton, 1979). The earliest mention of DACUM is 1966 where

DACUM was used as a new method for curriculum development at the Iowa Women's Job Corps in Clinton, Iowa. It was adopted by Nova Scotia NewStart, Inc. in 1968 for the development of curriculum for disadvantaged adult learners (Adams, 1975), and then by Holland College in Prince Edward Island in 1969. In 1975, Bob Norton was introduced to DACUM by the program development specialist at Holland College. In 1976, Norton facilitated his first DACUM workshop at Colorado State University, and since then has been a major advocate for DACUM as a method of occupational analysis for competency-based education (Norton & Moser, 2008). DACUM has recently expanded in scope encompassing both course and program development using a process called Systematic Curriculum and Instructional Development (SCID) (Finch & Crunkilton, 1979; Norton & Moser, 2007).

Three logical premises are the basis of DACUM according to Norton and Moser (2008):

> (a) Expert workers can describe and define their jobs/occupation more accurately than anyone else; (b) An effective way to define a job/occupation is to describe the tasks that expert workers perform precisely; and (c) All tasks, in order to be performed correctly, demand the use of certain knowledge, skills, tools, and positive worker behaviors (pp. 1-2).

According to Norton and Moser (2008), a 2-day DACUM workshop involves 5-12 expert workers from a role, occupation, job or position along with a trained facilitator. They say that the deliverable from that workshop is a detailed and graphic profile chart displaying detailed duties and tasks that comprise the role. Comprehensive lists of knowledge, skills, and traits are also identified for the role. Norton and Moser discuss

DACUM's value saying it has been successfully used to analyze a host of occupations including those in professional, managerial, supervisory, technical, skilled and semi-skilled levels. Moreover, it is highly effective, quick and has a low cost. Based on historical experience the scholars note DACUM panels normally result in strong employee buy-in to the outcome and process. Norton and Moser indicate that the keys to a successful DACUM workshop are a trained facilitator and the panel member's willingness to participate and communicate what they do. Other occupational analysis procedures do not have the same intrinsic benefit (O'Brien, 1989b; Willett & Hermann, 1989).

Adams (1975) summarizes the benefits of using DACUM saying, "the DACUM process lends itself quite ideally to the development of new training programs" (p. 38). O'Brien (1989b) in his study of health occupation education programs said, the "DACUM technique can be used to examine virtually any occupation, regardless of technical complexity, or level of responsibility" (p. 59). He goes on to speak about panels made up of members from specialty groups in health care. This addresses the panel for this study, which was made up of chaplains from different religious backgrounds and environments, a type of specialty group in health care. O'Brien, (1989b) says, "the resulting DACUM chart would be comprehensive in nature and would provide an adequate base for curriculum development" (p. 66). These three points are worth noting since the HealthCare Chaplaincy Network is now collaborating with California State University on a number of new training programs for chaplains, health care chaplains have not participated in a DACUM to date, and the panel was made up of participants from divergent backgrounds.

DACUM is informed by concepts such as facilitation (Schwarz, 2002), consensus building (Hartnett, 2011), and competency-based education (Norton, 2009). Curriculum development, of which there are many published models, is informed by the profile that DACUM delivers and helps to inform the DACUM process so that the needed data is gathered during the initial panel and validation panels. The following sections address each of these concepts along with examples of how DACUM has been used in research studies.

DACUM - Facilitation and Consensus Building

Facilitating a group occurs when a person is for the most part neutral, and has no authority to make a decision, helps a group through diagnosis and intervention identify and solve problems, make decisions, and improve its effectiveness (Schwarz, 2002).

DACUM utilizes brainstorming, discussion, and consensus-building strategies guided by a trained facilitator (O'Brien, 1989b). One of the key skills required of those conducting a DACUM panel is a high-quality set of facilitation skills (Norton & Moser, 2008). These skills include interpersonal communication skills, patience, confidence, a positive attitude for the DACUM process, sincerity and sensitivity for the panelists, and an overall enthusiastic persona. Norton and Moser continue saying, a good, trained DACUM facilitator is one who knows when to use these skills while establishing a trusting relationship and rapport with the panelists from the outset of the session. Hartnett (2010) believes that a trained facilitator who is skillful must be able to inspire the panel that he or she is working with.

Overall the DACUM facilitator's responsibility is to facilitate numerous small-group brainstorming sessions using a host of skills, all guiding the panel towards a level

of consensus in the analysis of the target occupation. As Norton and Moser (2008) clearly state, the key advantages of DACUM, apart from group interaction, are group synergy when a panel is properly facilitated, and group consensus with the guidance of a trained facilitator who helps the panel evaluate each contribution until the group reaches unanimous agreement. One who leads by facilitation is someone who does so by fostering collaboration (Hartnett, 2010). To reach consensus, ground rules are necessary.

At the beginning of a DACUM session ground rules would be established. These help the panel reach consensus over their time together. The ground rules articulated by the facilitator should include all panelists will participate equally; one person contributes at a time; suggestions should be constructive and not destructive or critical; all statements should be carefully considered; and finally, panelists should enjoy the process (Norton & Moser, 2008). Schwarz (2002) believes ground rules help establish a diagnostic frame and help a trained facilitator identify what is happening to the group process. One of the key reasons why some groups have a difficult time reaching consensus is an effective set of ground rules is not established. Understanding how DACUM is facilitated and the consensus outcomes that are possible is a foundational element of my study. If consensus is not reached because of poor facilitation, it would be difficult to address the four research question of my study. Next, I examine how DACUM is aligned with competency-based education.

DACUM and Competency Based Education

According to Norton and Moser (2008), competency-based education is any program of instruction that develops its content from verified tasks and centers assessment on the performance of a student. The tasks are the competencies, and these

must be identified and validated prior to delivering instruction. Competency-based education (CBE) has as the main focus the student's ability to perform a task, as well as to know the why and how.

According to Norton and Moser (2008), there are five key elements of a CBE program. The five key elements are:

- Competencies are identified, corroborated and made public in advance;
- Assessment criteria for achievement are clearly communicated and made public in advance;
- Individual development and evaluation of each defined competency is provided in the instructional program;
- Competency assessment requires a learner's performing the competency as the main criteria for achievement; and
- Learners may progress through a program at their own pace by demonstrating competency attainment.

DACUM is well aligned with CBE because the first key element in CBE is the identification of the tasks, or competencies, upon which the program is grounded. A DACUM profile quickly and efficiently provides a graphical representation of the tasks upon which a CBE program could be built. After the tasks are verified through a validation study, they could be communicated as the competencies to be covered in an instructional program.

Adams (1974) takes DACUM a step further by referring to it as a competency model that communicates a business' needs to educators and conversely can describe to a business what educators can provide to them. For Adams, a competency model, like

DACUM, should clearly describe the performance desired and provide some method of evaluating a learner's performance. In essence, DACUM provides a way to clearly answer the questions what do we have to produce, and, how do we show what we have produced. By being able to address these two questions, DACUM helps educators, and business alike in providing targeted education to students and employees.

By using competency models, such as a DACUM chart, employer's needs are communicated to educators and instructional designers, and educators and instructional designers can clearly communicate what they are providing back to employers (Adams, 1973). According to Adams, a competency model such as a DACUM chart is a representation or simulation of an employee's ability to perform in a specific area such as an occupation. "A DACUM chart …is a graphic, single-sheet description of the kinds of competence required in an occupation" (p. 40).

A Review of DACUM-based Research Studies

In order to show DACUM's versatility, I now examine several examples of some of the many ways that DACUM has been used in research studies. Cooper, Aherne, and Pereira (2010) "describes a Canadian Community of Practice process to develop an occupational analysis-based competency profile for the Professional Hospice Palliative Care Spiritual Care Provider (HPC) utilizing a modified Developing a Curriculum (DACUM) methodology" (p. 869). DACUM was selected to address the need for HPC-focused clinical education. In their research, they found DACUM's strengths to be its ability to target the core tasks of the role and what those in the role, and those who want to be in the role, need to learn. Cooper et al. (2010) reported that the DACUM profile led to the development of "a competency profile for one of its four current certifications" (p.

871). They concluded their report by saying that the DACUM profile for this role provided a formal contribution to a growing global discussion about the role's responsibilities, and tasks, and would benefit those interested in this role including certifying bodies and those developing a clinical training curriculum.

Johnson, (2010) demonstrated in a study of the GIS Technician role an excellent model for leveraging DACUM studies using a meta-analytic approach to update an occupational profile and provide the latest data for course development. Though this did not address my target audience, chaplains, it did show a research model where DACUM's strengths could be leveraged, and weaknesses overcome.

Stevenson, Hornsby, Phillippe, Kelley, and McDonough (2011) demonstrate in their study how DACUM could be used to not only develop curriculum but review course materials and assessments in several advanced pharmacy practice experience courses.

In Drake's dissertation (Drake, 1980) DACUM was used in the identification and verification of essential competencies for supervisors of vocational education in Pennsylvania. Drake (1980) recommended DACUM as appropriate for professional occupations and non-typical vocational education offerings where curriculum materials are not available. The deliverable from DACUM is real-world because those developing the curriculum plan are experts in the given role.

Kosidlak (1987), who was the director of Virginia's Department of Health, Public Health Nursing, described how public health maternity nursing competencies were arrived at using DACUM. Historically she says, this initiative came to be as the result of the State of Virginia expressing concern for the state of health care for poor mothers and children in the 1980s. They saw that the depth of knowledge and skills, content and

scope that maternity nurses should have had not reached consensus. As a result, public health leaders across Virginia decided to develop a set of competency standards, which could be used for "orientation, continuing education, and evaluation of maternity nursing care" (Kosidlak, 1987). To accomplish this DACUM was selected as the process of choice. The competencies that resulted from the DACUM process have been used for recruiting notices, questions used in interviews, and selection criteria. Kosidlak concluded by saying, that they recommend DACUM as "an alternative or adjunct to traditional methods of developing competency models" (Kosidlak, 1987, p. 20).

Seibert and Mauser (1979) discovered some of the uses of the DACUM chart. In a study of medical assistants, notable uses of a DACUM chart were: (a) describing the field to external agencies; (b) identifying the entry-level competencies for those interested in pursuing a career; (c) establishing educational standards for practitioners in the field; (d) identifying functions categorized as advanced; (e) providing a foundation for continuing education; (f) establishing criteria for certification examinations; and (g) providing a foundation for curriculum development.

When studying a DACUM profile of bank tellers in Maine, O'Brien (1989a) found the DACUM profile yielded a highly reliable task listing. The DACUM profile also was supported when looked at in terms of construct validity. It "possessed substantial validity as a single construct subsuming the entire listing…DACUM duty areas also possessed substantial construct validity, each being unidimensional in composition when analyzed separately and highly interrelated when analyzed together"(O'Brien, 1989a, p. 34). These results indicate that the DACUM profile

accurately described the bank teller occupation, and the profile contained an organizational structure that was genuine.

Engleberg and Wynn (1995) proposed using DACUM to justify a study of speech communication in higher education. They analyzed 75 DACUM charts and found 97% had speech communication competencies. The DACUM charts reviewed helped them demonstrate the importance of communication studies in higher education. They went on to state that, "in addition to functioning as a source of data, DACUM can also be used as a means of validating other instruments used in communication research" (Engleberg & Wynn, 1995, p. 34).

Linton et al. (2011) used DACUM to analyze the food protection and defense occupation. This was significant since one of the areas of national vulnerability identified since September 11, 2001, was the U.S. food supply. This team of researchers studied the knowledge, skills, duties and tasks for this critical occupation, validated their findings through surveys, and delivered a training program with computer-based simulations where students had to respond to a mock event where food was intentionally contaminated. The interesting point to this three-part study is that the researchers were able to deliver not only a DACUM profile detailing what is done by those in the role, but also a task analysis which defined how each task was done and the knowledge, skills, and abilities needed to successfully perform each task. For example for the task, assess food system for risks and vulnerabilities, seven steps were identified, and twelve knowledge, skills, and abilities were listed. The researchers noted in their closing that a number of core knowledge domains defined in the DACUM profile aligned with Department of Homeland Security priorities, most importantly that food defense professionals must

possess an interdisciplinary understanding of food systems and agriculture, which require customized training solutions for this occupation.

Halbrooks (2003) studied the use of DACUM at Kent State University for the development and revision of the horticultural curriculum content for an associate degree program. Citing Norton, one of the reasons Halbrooks advocates for DACUM is it allows educators to establish a relevant, up-to-date, and localized curriculum foundation for instructional programs. According to Halbrooks, this study showed how DACUM is a powerful tool for curricular development and revision as shown in the practice of horticultural education. Since DACUM relies on experts in the occupation for painting the profile of skills needed by graduating students, Halbrooks affirms that those who use DACUM would be able to experience it as a tool for "content-determination" (p. 576). Halbrooks concludes by issuing the following caveat, "the educator's role in this process is best applied after the content determination process has been finished and involves shaping the skills profile into a working curriculum" (p. 576).

In Lewis' (1992) dissertation study DACUM was used to identify the competencies needed by missionaries being sent out to the *"southern cone"* of Latin America. The DACUM panel consisted of a large group of missionary training stakeholders in the region. The total number of panelists was over 60 requiring Lewis to modify the DACUM methodology to accommodate this large number of participants. The profile that resulted included 14 major areas of training or duties, and 128 tasks or competencies. Lewis conducted a survey-based verification study by contacting the directors of 107 worldwide missionary training centers. Sixty-five centers responded, and after statistical analysis, all but one competency was aligned with the initial profile.

Lewis concluded that the DACUM profile accurately represented the competencies needed by missionaries in Argentina. Because of the statistical agreement demonstrated between the initial profile and the verification study, Lewis also stated the resulting competencies could be useful for missionary training in other areas of the world. One interesting side note from Lewis' study of missionary training competencies is it apparently generated a good bit of attention since two other dissertations (Agron, 2002; Strauss, 2008) on missionary training competencies using DACUM cite Lewis' work as a landmark.

The dissertation study conducted by Fortuna (1996) was the spark that initiated this study of health care chaplains. Fortuna studied medical administrative assistants working in physician offices in South Florida. In trying to identify competencies for this occupational role she noted three problems: (a) there was little or no academic curriculum available for this health care role, (b) the role that medical administrative assistants filled in health care could best be described as diverse, and (c) health care is complex and rapidly changing. In order to succeed in the role, one must receive up-to-date training. In order to develop targeted training for a diverse role, an analysis was required. Fortuna chose DACUM because it was best suited to analyze a role for which no programs existed. Fortuna's initial panel identified eight duties and 71 tasks for the role of medical administrative assistant. This panel leveraged standard DACUM philosophical practices where brainstorming was used to reach group consensus. Her validation study which was survey-oriented only questioned three of the initial panel's tasks but not to the degree that she would dismiss them. One of Fortuna's recommendations was to develop a curriculum framework for this role, with the first step being the formation of a curriculum

committee. In summary, she recommended another DACUM, or minimally a validation study be conducted in 5 years to ensure that health care's understanding of the role is keeping pace with all of the complex changes occurring.

In summary, I have shown how DACUM has been used in health care, specifically for palliative care, pharmacy technicians, nursing, medical assistants, and medical administrative assistants. I have also reviewed how DACUM has been used in education specifically for vocational education, higher education speech curriculum, and higher education horticulture. For the government, I have shown how DACUM has been used for the role of GIS Technician and post 911 for those involved in food protection. Finally, I have demonstrated how DACUM has been used for defining missionary training in Argentina. So DACUM has been used in the government, in education, in health care, and in training those whose careers are religious in nature. These studies helped to inform this study by demonstrating DACUM's versatility across a wide span of roles and professions and by providing documented ways that DACUM profiles have been used for curriculum development, for defining a role, and for certifying members of a profession. These studies provide evidence that a DACUM analysis of health care chaplains would provide data that could enhance the profession, training standards, and future curriculum development offerings.

Summary

In a study conducted by Flannelly et al. (2004) on factors affecting health care chaplaincy, the researchers said, "little research has been done that documents the role chaplains play in health care settings, or the place of chaplaincy and pastoral care with the health care system" (p. 127). This has only been partially addressed in the last 10

years. Based on perspective there is not a single, accepted profile of the role. De Vries et al. (2008) clearly identify the issue when they say, "the precise duties of their job are unspecified" (p. 24). Health care chaplains serve many functions, some of which have been documented or researched to date. This could be accomplished using a widely used occupational analysis methodology, like DACUM. DACUM is quick, efficient, and evokes buy-in from leaders and those in a researched role (Norton & Moser, 2008). The profile that results from a DACUM panel, when validated, could be leveraged by a number of curriculum design models that are based on an ISD framework. These include ADDIE, Successive Approximation, and SCID (Wyrostek & Downey, 2016).

If the role of health care chaplain were researched using DACUM, the resulting profile might impact the current way chaplains are educated and certified. An agreed upon profile might help to clarify standard, objective, and outcome definitions. When looking at the ACPE Standards for a Basic unit of CPE, there are few references that are directly applicable to the role of health care chaplain. Most standards are role-agnostic in order to embrace and attract the varied ministries represented by seminary students. The Core CPE Curriculum used by HCCN does a better job with their objectives being focused on the role.

Three issues emerge when the ACPE standards and the HCCN Core Curriculum are examined. First, CPE supervisors are able to customize the curriculum for their site and based on their style and philosophy. There is no standard curriculum. Could that be changed if there is a clear role definition? Second, as Cadge (2012) points out basic courses about health-care administration, counseling, research methods, and substantive topics such as medical ethics-information are needed and not addressed in either set of

standards or objectives. If CPE is the training ground for health care chaplains, should students not be exposed to a curriculum and transformative experiences that adequately prepare them for the role? Or is the reason that role specific courses are not part of a training curriculum because the role is not defined by those in the role? According to Norton and Moser (2008), the best resources to define what is done in a role are those experts in the role. Third, if the goal of CPE is broader than training health care chaplains, should there not be role-specific training and certification paths within CPE for those wishing to be parish priests, military chaplains, rabbis, or work in pastoral and family counseling, or health care chaplains? The solution might be as simple as a curriculum path and certification roadmap that is role specific and addresses each roles duties and tasks. From examining the literature, it appears that CPE is trying to be all things to all roles and as a result, the role of health care chaplain has not been granted a professional status and has lost clarity within modern-day health care. A DACUM on the role might help the standards, CPE and the role of health care chaplain by addressing the issue of role-confusion that currently exists.

This brief literature review outlines some of the current gaps that were addressed by an occupational analysis using DACUM of the health care chaplain role. It provided insight into the potential curriculum used by CPE supervisors to train new chaplains.

Chapter III

METHODOLOGY

Overview

A mixed methods case study approach, with an emphasis on qualitative methods, was selected for this study. The selected approach was well suited for investigating unique and complex cases in health and health care that are complex, such as the case with the role of health care chaplain (Fetters, Curry, & Creswell, 2013). Despite my background and experience, I was not sure what I would find in this exploratory DACUM analysis of the health care chaplain role. I wanted to be open to generating rich, detailed data that would reflect what the various panels agree is an accurate picture of what chaplains do and need to know. The data included some basic quantitative statistics and qualitative data, primarily from DACUM panels, semi-structured interviews, and surveys. For the purpose of this study, the term focus group and panel are synonymous, though in DACUM studies the preferred choice is the term panel.

I examined one cross-section of chaplains in the metropolitan New York City area, affiliated with one organization (The HealthCare Chaplaincy Network) which currently partners with a number of health care institutions in the area and several cities across the United States. Of the 19 chaplains who participated on the first three panels and helped develop and validate the profile of a health care chaplain, 13 were paid employees of HCCN and six were not. Of those same 19, only three identified with

HCCN while 16 preferred to identify themselves with the hospital they were serving daily.

I wanted to investigate if the DACUM process, taught at Eastern Kentucky University, could be used to generate an accurate occupational profile of a health care chaplain. To ensure greater accuracy, two panels reached consensus on a profile that represents what health care chaplains didand need to know to function successfully in health care settings today. In addition, I wanted to assess if a panel of curriculum developers and a panel of Clinical Pastoral Educators can use the profile to develop curriculum and deliver training for future learning interventions.

My role in this study was as a participant observer (Patton, 2002). I served as facilitator for all panels as well as the interviewer for all semi-structured interviews. Since I have established relationships in the past with some of the leaders of The HealthCare Chaplaincy Network and was trained in CPE many years ago, my background gives me a point of historical reference with the chaplains who served on the panels and whom I would interview.

I present the methodology for this study in two parts. First, I detail my plans for sampling, data collection methods, and data analysis. Second, I present tables that detail each of these three elements and show in Appendix K how they address each of my four research questions-one table per question. Some researchers prefer to provide a methodology simply detailing sampling, collection methods, and methods of data analysis. Other researchers prefer a presentation focused on the research questions. Because I was conducting a somewhat complex study, I will present my methods both ways. I conclude with a brief summary.

Research Design

"The DACUM process incorporates the use of a panel in a facilitated storyboarding process to capture the observations of high performing incumbent workers regarding the major duties and related tasks included in an occupation" (EKU Facilitation Center, 2011, p. 334). Following the Eastern Kentucky University model, a DACUM analysis that could be used for curriculum development required four panels. This model called for an initial panel with representative panel members, who are experts in the role, selected by agency staff. Once the initial profile was developed, it was presented to a second group of experts in the role, not included in the initial panel, for comments, edits, additions and deletions, and validation. A formal leadership or management review was then conducted by a third group. The final product was then presented to a curriculum development team for feedback on the design and development capabilities. One modification was made to the EKU model to address the issue of geographic generalizability. To the four standard panels, a fifth was added to validate the profile across the five major regions of the United States.

Applying the modified EKU model to this study, the five panels were (a) Panel 1 - an initial DACUM panel of health care chaplains, (b) Panel 2 - a validation DACUM panel of health care chaplains, (c) Panel 3 - a panel of CPE supervisors (educators) which took the place of the leadership review in the generic model, (d) Panel 4 - a panel whose focus is curriculum development, and (e) Panel 5 - a geographically diverse validation panel of health care chaplains.

Sampling Methods

The members of each panel were purposefully selected by an industry expert using criterion standards to guide the final selection (Patton, 2002). Panel 1 was composed of a cross-section of nine experts within the health care chaplain role from the New York Tri-State area. Panel 2 was composed of six experts within the health care chaplain role from the New York Tri-State area. Panel 3 was composed of four experts within the CPE supervisor role from the New York Tri-State area. Panel 4 was composed of three experts within the CPE supervisor role who were also expert curriculum developers. Panel 5 was composed of 11 experts within the health care chaplain role; two each from the Northeast, Southeast, Southwest and West and three from the Mid-West.

To identify the panelists, I worked with an industry expert, the Senior Director of Chaplaincy Services and Clinical Education of The HealthCare Chaplaincy Network. He identified chaplains who fulfill the following criteria: have 2 or more years of experience and represent a cross-section of chaplains based on race, gender, and religious affiliation. His selections were cross-checked by the Director of Health Services, Research, and Quality. The chaplains were selected as High Performing Incumbent Workers (EKU Facilitation Center, 2011), who are experienced in their role and who were willing to verbally participate in the sessions. These panelists had real-world knowledge of what health care chaplains did on a day-to-day basis. I wanted a balanced representation of men and women, races and ethnicity, and religious affiliations so that the final profile represents what a typical health care chaplain does and needs to know from this geographic region. The purposeful, or expert selection, was augmented with

searches on LinkedIN to fill in any gaps that occurred on this panel. The goal for the selection of participants was to achieve a cross-section of health care chaplains, supervisors and curriculum developers based on race, gender, and religious affiliation, and chaplains who have 2 to 5 years or more experience.

The reason for seeking a cross-section of health care chaplains is the New York City metropolitan area and its' health care institutions are comprised of a multifaith, multicultural population. To accurately reflect the typical role of health care chaplain working in the New York City area, the goal was to have a cross-section of participants based on race, gender, and religious affiliation.

According to DACUM scholars such as Adams (1975) and Norton and Moser (2008), after the initial panel, a validation study is conducted with either all members in the role through an online survey, or a second panel to review the data generated by the initial panel. The validation panel in this study was composed of a cross-section of six experts within the health care chaplain role from the New York Tri-State area as identified by the Senior Director of Chaplaincy Services and Clinical Education of The HealthCare Chaplaincy Network and cross-checked by the Director of Health Services, Research, and Quality. The validation panel was purposefully selected using criterion sampling (Patton, 2002). The same criterion of race, gender, experience, and religious affiliation as used for the initial panel guided the selection of the validation panel. One goal for this panel's selection was to fill any demographic gaps experienced in the initial panel while having a representative cross-section of available health care chaplains. Final selection was based on the criterion used to achieve a cross-section of health care chaplains.

The third panel, CPE supervisors (trainers) panel, was composed of four experts who were experienced CPE supervisors and whose job it was to teach student chaplains using the Clinical Pastoral Education model. The participants for this panel were initially identified by the current Senior Director of Chaplaincy Services and Clinical Education of The HealthCare Chaplaincy Network and cross-checked by the Director of Health Services, Research, and Quality. Primarily, the criterion sampling technique was used to identify participants. Final selection was based on the criterion used to identify a representative panel of CPE supervisors. These supervisors had real-world knowledge of what those in the health care chaplain role do on a day-to-day basis.

The purpose of this panel was to evaluate the final profile, passed to them from the initial and validation panels, to comment and provide editorial guidance on whether the profile would impact the training they deliver, and, if so, how it would impact it. Since this panel's purpose was to evaluate the profile for training delivery, I was open to experienced CPE supervisors who formally were associated with HCCN but are not currently. This included participants from outside the New York City area.

The fourth panel, the curriculum development panel, was made up of stakeholders and experts from the field of curriculum design and development. This panel was made up of three participants which did not meet the accepted minimum for a DACUM panel but since this was an ancillary leadership panel it was acceptable (Norton & Moser, 2008). The purpose of this panel was to evaluate the final profile passed to them from the initial and validation panels and the CPE supervisor panel. They were asked to comment and provide editorial guidance on whether the profile was a viable source for the design and development of future curriculum offerings for health care chaplains. This panel was

facilitated as a virtual panel several weeks after the profile was digitized and distributed to the members of this panel. Primarily, the criterion sampling technique (Patton, 2002) was used to identify panelists with most important criteria being knowledge, education, and/or experience in the design and development of curriculum. Final selection was based on the criterion used to identify a panel of experienced curriculum designers and developers. The panelists were identified by the current Senior Director of Chaplaincy Services and Clinical Education of The HealthCare Chaplaincy Network and cross-checked by the Director of Health Services, Research, and Quality. He identified participants who are High Performing Incumbent Workers (EKU Facilitation Center, 2011), who are experienced in curriculum design and development, and who were willing to verbally participate in the sessions. These curriculum developers had real-world knowledge and experience in the role of curriculum development.

The fifth panel was an additional validation panel. According to DACUM scholars such as Adams (1975) and Norton and Moser (2008), after the initial panel, a validation study is conducted with either all members in the role through an online survey, or a second panel to review the data generated by the initial panel. The fifth panel functioned as a validation panel in this study was composed of a cross-section of 11 experts within the health care chaplain role with a minimum of two from each of the five geographic regions of the U.S. These participants were identified by the current Senior Director of Chaplaincy Services and Clinical Education of The HealthCare Chaplaincy Network and cross-checked by the Director of Health Services, Research, and Quality. The same criterion of race, gender, experience, and religious affiliation as used for the initial panel guided the selection of this fifth panel. I limited this panel to no more than

12 participants since this is the accepted maximum for a DACUM panel (Norton & Moser, 2008). This also becomes a workable number since the number of available chaplains was unlimited across the five regions of the U.S. One goal for this panel's selection was to fill any demographic gaps experienced in the second panel while having a representative cross-section of available health care chaplains. Final selection was based on the criterion used to achieve a cross-section of health care chaplains.

Participant Orientation

Once the volunteer participants for the first four panels were identified, they were invited by email to an online web conference that was conducted using Cisco's WebEx product. The web conference was conducted approximately 1 month prior to the panels meeting face-to-face at the HCCN office in lower Manhattan. During this webinar, panelists received an overview of this research study, its purpose, and an overview of the DACUM process. Photos I have taken of other DACUM analyses that I have facilitated were shown along with a few prepared PowerPoint slides that are part of the literature provided to those who are trained in the DACUM process at Eastern Kentucky University (EKU Facilitation Center, 2011). Participant responsibilities and scheduling were presented to the participants also. Participant responsibilities included panel participation and one 30-45 minute recorded, telephone interview with me, after the panels meet. They were informed of the fact that they were volunteering their participation in a research study. In addition, they were informed that aggregate data from this study would be reported and published, but names would be anonymized. All participants were assigned a code for reporting purposes on day one of their panel meeting. Participants on the initial panel were assigned a code of C1-C12. Participants on the validation panel

were assigned a code of V1-V12. Participants on the CPE supervisor panel were assigned a code of S1-S12. Participants of the curriculum development panel were assigned a code of A1-A6. In additiion, paricipants on the fifth panel, the geographically diverse validatiion panel, were assigned a code of G1-G12. They were informed that they can leave at any time without fear of retribution. In addtion they were informed that on day one of their panel meeting they would be asked to sign a University approved Informed Consent form as seen in Appendix F and complete a brief demographic survey, as seen in Appendix C, that would be distributed within the first 90 minutes of meeting. At this point in the webinar, questions were fielded. After a brief question and answer exchange, all participants were asked to respond to the following WebEx poll question:

> Based on the information provided in this webinar, are you willing to voluntarily participate on your agreed upon panel in the research study, A DACUM Analysis of Health Care Chaplains in Metro New York and The Implications for Clinical Pastoral Education? If yes, select yes in the Polling window. If no, select no.

This poll question will serve as a binder indicating informed consent prior to the initial face-to-face meeting.

Data Collection Methods

As Maxwell (2013) recommended, multiple methods of data collection were used to provide a means of validation via triangulation. In addition, multiple methods of data collection enabled the study of different aspects of the role of health care chaplain. DACUM panels provide one view of the role. The sources of data collection for this mixed methods study were (a) panels in the form of DACUM panels, (b) interviews, (c) surveys, (d) facilitator journal memos including photo documentation of the profile

evolution, and (e) a prioritization coding exercise performed during the initial, validation, and CPE supervisor panels.

Surveys

Two types of surveys were used. These surveys were checked for content validity by an expert in the field of health care chaplaincy research, the Director of Health Services, Research, and Quality, for the HealthCare Chaplaincy Network (HCCN). Recommended changes were made to ensure that the survey items aligned with the defined research questions.

The first survey was a demographic survey (Appendix C) written in such a manner to gather data about each participant's race, gender, experience, and religious affiliation. This was administered within the first 90 minutes of each panel's face-to-face meeting. Each participant was assigned an anonymous code that they wrote on the top of the survey. This helped keep participants anonymous while allowing me to determine frequencies and basic descriptive statistics concerning the panel's make up. For example, from this survey I was able to report the mean number of years of chaplaincy experience for each panel and for the study. This type of data helped address research questions 1bi and 2bi,

At the end of each day's session, each participant was asked to complete a short pencil and paper survey as seen in Appendix D, to assess the most satisfactory, successful, and challenging aspects of the DACUM process. Each panel that I met with in person or virtually, was asked the following questions, using a 5-point Likert disagree-agree scale for first six questions and open comment boxes for the remaining questions. These questions were based on this study's research questions, and are derived from the

end of sessions satisfaction questions used by DACUM facilitators trained at Eastern Kentucky University (EKU Facilitation Center, 2011).

1. I understand the purpose of the research study using the DACUM process.
2. I expect the profile that results from this study will positively influence the role of health care chaplain.
3. The occupational profile developed so far accurately reflects what I do day-to-day.
4. I found the DACUM process to be a good way to develop a profile for a health care chaplain.
5. I found the DACUM process to be challenging.
6. I found the DACUM process to be a success.
7. The most satisfactory aspect of the DACUM process has been ….
8. The most successful aspect of the DACUM process has been ….
9. The most challenging aspect of the DACUM process has been ….
10. What are your thoughts, positive, negative, or neutral about the profile of the health care chaplain developed?
11. If this process was repeated in the future, with other panels of health care chaplains, what recommendations to the process would you like to see implemented?
12. My assigned anonymous code is ….

Interviews

Panelists were asked to participate in one-on-one telephone interviews after their panel convened to document their initial perceptions and, later their satisfaction,

successes, and challenges. All interviews were digitally recorded, transcribed, and thematically coded. These interviews were semi-structured following an interview guide similar to the one used by Barrows (1993) in his sociological study of hospital chaplains. Galletta (2013) promotes using semi-structured interviews in a multi-methods study because it's key benefit is its attention to real-world experience while still addressing theoretical variables. It is a way for researchers to elevate a study to an in-depth exploration of a process. Seidman (2013) is an advocate for interviewing in educational research where a process, such as DACUM, is being investigated. It is through the experience of those involved in the process that one gains a fuller understanding of the process.

These interview items for the interviews were checked for content validity by an expert in the field of health care chaplaincy research, the Director of Health Services, Research, and Quality, for the HealthCare Chaplaincy Network (HCCN). Recommended changes were made to ensure that the interview items aligned with the defined research questions.

The interview explored the following questions, which were a follow up to the survey questions asked at the end of the sessions. Not all questions were used. Rather, they were used to guide the conversation, allowing me to stay open to follow where the interviewee takes me. Barrows (1993) interview guide, and the items contained within, served as a model for the development of these items. The questions I asked and the research question(s) (RQ) that each addressed were the following.

- Based on the panel you participated on, the most satisfactory aspect of the DACUM process was …. (RQ 1b, 1bi, 2b, and 2bi)

- Based on the panel you participated on, the most successful aspect of the DACUM process was …. (RQ 1b, 1bi, 2b, and 2bi)
- Based on the panel you participated on, the most challenging aspect of the DACUM process was …. (RQ 1b, 1bi, 2b, and 2bi)
- Did the final DACUM profile capture what you do in your role of health care chaplain? What would you change? (RQ 1b, 1bi, 2b, and 2bi)
- What are your thoughts, positive, negative, or neutral about the profile of the health care chaplain developed? (RQ 3, 3a, 4 and 4a)

Panels

According to Krueger and Casey (2009), a panel study is a "carefully planned series of discussions designed to obtain perceptions on a defined area of interest in a permissive, nonthreatening environment" (p. 2). For this study, four panels in the form of DACUM panels were convened. Each panel contributed their perceptions on the role of health care chaplain in a very open, safe environment.

The initial panel was scheduled from 8:30 am to 5:00 pm on Monday to Wednesday of the agreed upon week. The initial panel went go through the 3-day framework where they collectively developed a DACUM profile in the form of a storyboard that detailed the duties and tasks performed by health care chaplains. In addition, as the panel worked through the process they listed the requisite knowledge, skills, traits, and tools leveraged by expert health care chaplains. The agenda for the initial panel contained the following steps:

1. Introductions and Overview
2. Demographic Survey and Consent Form

3. Job Description
4. Develop Duty Band 1 (Task List)
5. Develop Duty Bands
6. List Knowledge, Skills, Traits, and Tools (KST)
7. Review Job Description
8. Review KST
9. Complete Duty Bands
10. Edit and Sequence Bands
11. Time Allocation Exercise (Actual/Future)
12. Rank Duties (Actual / Future)
13. Prioritization Coding Exercise
14. Final Review of Job Description
15. Debrief

One of several prioritizing exercises (Agenda Item 13, above) practiced by facilitators trained at EKU on the final day of the panel has the initial panel participants apply colored dots to those tasks, knowledge, and skills that they perceive as being new worker or veteran worker training needs. Green dots are applied for new worker training needs and yellow dots are applied for veteran worker training needs. These dots had the participants' anonymous code written on them to indicate, from the participants' vantage point, the training needed for new workers and veteran workers. This addressed Research Question 1a. Duties were presented, with a rectangular border, on the far left of a band or row. Tasks did not have a border.

Part of the coding prioritization exercise is to identify those tasks that are critical to the role and those that are done most frequently. Participants received one dot of each color for each 10 tasks identified on the profile. For new worker and veteran worker training needs an additional dot were distributed for every 10 knowledge and skills identified during the panel. For the CPE supervisor panel, teaching difficulty also was identified. The key for the color coding is shown in Figure 2.

Prioritization Coding Key

Metric	Color	Element Coded	Panels
Crticality	Red	Tasks	1,2
Frequency	Blue	Tasks	1,2
New Worker Training Needs	Green	Knowledge,Skills, and Tasks	1,2
Veteran Worker Training Needs	Yellow	Knowledge,Skills, and Tasks	1,2
Difficult to Learn	Orange	Tasks	1,2
Diffcult to Teach	Silver Gray	Tasks	3
Easy to Teach	White	Tasks	3

Figure 2. Prioritization Coding Key

The second set of panels to convene are validation panels. Historically the time required for a validation panel is a half-day to 1 day. According to the guidance provided to those trained under the Eastern Kentucky University DACUM facilitation model, validation of a profile occurs with any subsequent review of the data (EKU Facilitation Center, 2011). "Generally, an initial panel followed by one or two validation panels is adequate for the development of a reliable job profile" (EKU Facilitation Center, 2011, p. 230). In this study, technically three validation panels were conducted.

For this study, I convened a three-part validation. The first part was a validation panel-Panel 2. The second part was a CPE supervisors panel-Panel 3. The third part was the geographically diverse validation panel-Pane 5. The validation panel of chaplains,

Panel 2, reviewed the initial panel's profile, as well as their lists of knowledge, skills, traits, and tools. They were asked to suggest changes, additions, and deletions. In addition, they were asked to go through the prioritization exercise for training needs and learning difficulty. The validation panel applied the same color dots using their assigned anonymous code to distinguish them from those placed by the initial panel. The data from the Panel 2 prioritization exercise addressed Research Question 2 and 2a. The agenda for the validation panel, Panel 2, contains the following steps:

1. Introductions and Overview
2. Demographic Survey and Consent Form
3. Review and Edit Knowledge, Skills, Traits, and Tools (KST)
4. Review and Edit Duty Bands
5. Rank Duties (Actual/Future)
6. Prioritization Coding Exercise
7. Final Review of Profile
8. Debrief

Steps three through six were the primary focus of the validation panel. The validation panel was scheduled from 9:00 am to 4:00 pm on the Thursday immediately following the initial panel proceedings. The CPE supervisor panel convened on the next day, Friday from 10:00 am to 1:00 pm.

Immediately following the validation panel of chaplains, a panel of CPE supervisors, who educate chaplains, met to review the final products provided by the initial panel and validation panel. A full review of the profile, lists, and prioritizations were explained. The panel was then asked whether the final products meet their

expectations and needs as trainers. They were asked to identify, from their perception, the strengths and weaknesses of the profile. Finally, they were asked from their position as an educator, which components of the final products were the easiest and the most difficult to implement in a training intervention and what challenges they anticipate in implementing the profile into their training routines. Finally, they were asked to go through the Prioritization Coding exercise using their assigned anonymous code and apply dots to those tasks that they consider difficult to teach. Notes were taken during this panel and the discussion were recorded, transcribed, and thematically coded. The data gathered from the CPE supervisors panel addressed Research Question 3.

The data from the first three panels was then translated to a digital format and distributed to all panelists. It was also distributed to the curriculum development team and Panel 5, the geographically diverse validation panel. A period of 4 weeks was given for review and then the curriculum development team was asked to meet for a 2-hour web conference to discuss the final products from a curriculum developer's perspective. A full review of the profile, lists, and prioritizations were explained and questions answered. The team was asked whether the final products met their expectations and needs as curriculum developers. They were asked from their perception to identify the strengths and weaknesses of the profile. Finally, they were asked, from their position as a curriculum developer, which components of the final products were the easiest and the most difficult to implement in a future curriculum as well as what challenges they anticipate in implementing the profile into new curriculum. Notes were taken during this meeting, and the discussion were recorded, transcribed, and thematically coded. The data gathered from the curriculum development panel will address Research Question 4.

A week after meeting with the curriculum development team, I began inviting chaplains from around the U.S. to participate on Panel 5. After several emails I had 11 willing volunteers to whom I emailed the profile as shown in Appendix H. After giving them 2 weeks to review I emailed them the following questions:

- Does this profile accurately reflect what you do in your role as a health care chaplain?
- Does the profile developed in NY transfer to your geographic region?
- If it does, please identify elements that are an accurate reflection.
- If it does not, please identify those elements that are not an accurate representation or gaps that you have identified.

The panelists were given 2 weeks to respond and all 11 responded in a timely fashion.

All telephone interviews, web conferences, and DACUM panels were digitally recorded and transcribed. Telephone interviews were recorded using an Olympus WS-802 recorder using an Olympus TP7 microphone. Web conferences using Cisco's WebEx product, including the curriculum development panel were recorded using the built-in WebEx recording functionality. The initial, validation, and CPE supervisor panels were recorded using two Zoom H4N digital recorders.

Journal Memos

Memos are "any writing that a researcher does in relationship to research" and help to "facilitate reflection and analytic insight" (Maxwell, 2013, pp. 19-20). I maintained a memo journal of facilitator reflections of the various panels' demeanor, participation, conflicts, and input. I also memoed all interviews and interactions I had

with participants. These included observational memos and reflective memos. Part of the journaling process was profile notes, which are any notes I made that specifically related to the developing storyboard profile that the panels developed. These included coding changes or notes to clarify what panelists were saying, or notes to provide context. In addition to the written journal memos, I created a photo journal shown in Appendix G, of all in-person panel sessions to graphically record profile changes over the course of the three panels using a Nikon D5100 DSLR camera.

Data Analysis Methods

As there were multiple methods used to collect data for this study, there was multiple methods of analysis used. Data analysis was going on at the same time as data collection was occurring. The analysis included reviewing over 48 hours of interview transcripts, panel transcripts, observational notes, and journal notes and memos using thematic coding. Analysis of the profile's development using profile notes and a photo journal was a second step in the analysis. Profile notes and a photo journal helped explain which duty bands were representative of all participants and which duty bands were representative of a subset of participants. For example, there were duties and tasks that changed dramatically from the initial panel to the validation panel. Analysis is part of the protocol followed by DACUM facilitators trained at Eastern Kentucky University. Asking questions like why this dramatic change occurred, and what are the implications for training and curriculum development were key to understanding the final profile and addressing the research questions. Finally, survey data descriptive statistics and statistical frequencies from the prioritization coding exercises were analyzed.

As Maxwell (2013) recommended, listening to recorded interviews and reading interview transcripts should be one of the first analytical methods used from the outset of this study. Memos and notes were written, and initial categories and tentative relationships identified during this initial analysis step. After listening and reading, transcripts and memos were thematically coded and categorized. Links between themes were identified. The protocol that was used for the analysis of DACUM panel recordings, interviews, recorded web-based meetings, memos, journal and observational notes, and profile notes is the seven-step process advocated by Creswell (2014).

The steps used in this protocol are:

- Data is organized and made ready for analysis which includes transcription.
- All data is reviewed providing a general feel for the material.
- All data is coded, chunking the data into categories. Coding can be done using pencil and paper.
- The coding process allowed the development of a description of the panels, and five to seven themes or categories that capture the principal findings of the study.
- Show how the description and themes were incorporated into the final narrative.
- Develop an interpretation of the data and consider the lessons learned.
- Validate my interpretation of the data. Interpretations of the interview data, and the journal and observational notes, were validated primarily using member checking.

Member checking was used to determine the accuracy of my findings and interpretations by taking back to six of the participants' significant parts of the transcripts, such as major findings and themes, to solicit feedback about my data and

interpretations. Member checking was an important technique that helped to rule out the "possibility of misinterpreting the meaning of what participants say and do" (Maxwell, 2013, p. 126). Member checking was also a valuable method of identifying my biases, while ensuring that I accurately represent the participants' position. In addition to member checking, I asked two senior level researchers, not affiliated with the study, to review portions of the data for their interpretation. Consulting with two senior level researchers provided an unbiased perspective and allowed me to see what I misinterpreted, what I have completely missed, and what I have may have interpreted correctly.

Survey data were analyzed for basic descriptive statistics from the Likert-type questions while open-ended questions were thematically reviewed and analyzed. The demographic survey data were analyzed using basic descriptive statistics looking at means and frequencies. The data were cross-referenced with the data from the prioritization coding exercises to respond to several research questions and to identify tasks that are linked to a given demographic. For example, if task B4 had seven green dots applied to it I could report that the panels thought it was an important task requiring new worker training.

Question and Methods Linked

I have provided a detailed overview of the sampling, collection, and analysis multiple-methods leveraged for this study. What I have not systematically done is mapped my research questions to these methods. Maxwell (2013) advises researchers to create a matrix, shown as a table in his text, where research questions are mapped to one's methods of sampling, data collection, and analysis to ensure that the questions and

methods are compatible and coherent. To address this recommendation, I have created a matrix for each research question. In the next section, I review my research questions and then present the tables shown in Appendix K:

- Tables K1, K2, and K3 - address Research Question 1, and all sub questions.
- Tables K4, K5, and K6 - address Research Question 2, and all sub questions.
- Tables K7, K8, K9, and K10 - address Research Question 3, and all sub questions.
- Tables K11 and K12 - address Research Question 4, and all sub questions.

Research Questions Mapped to Methods

In fulfilling this study's purposes, I answer the following questions:

1. From the perspective of the initial DACUM panel of health care chaplains, what are the competencies, i.e., duties, tasks, knowledge, skills, traits, and tools, identified for the role of health care chaplain?
    a. From the perspective of the initial DACUM panel of health care chaplains, what knowledge, skills, and tasks are identified as new worker training needs, and veteran worker training needs?
    b. From the perspective of the initial DACUM panel of health care chaplains, what are the most satisfactory, successful, and challenging aspects of the DACUM process?
        i. On the initial panel, how does race, gender, experience, and religious affiliation influence the health care chaplains' perception of what is satisfactory, successful and challenging?

2. From the perspective of the validation DACUM panel of health care chaplains, what are the competencies, i.e., duties, tasks, knowledge, skills, traits, and tools, identified for the role of health care chaplain?
    a. From the perspective of the validation DACUM panel of health care chaplains, what knowledge, skills, and tasks are identified as new worker training needs, and veteran worker training needs?
    b. From the perspective of the validation DACUM panel of health care chaplains, what are the most satisfactory, successful, and challenging aspects of the DACUM process?
        i. On the validation panel, how does race, gender, experience, and religious affiliation influence the health care chaplains' perception of what is satisfactory, successful and challenging?
3. From the perspective of the CPE supervisors, who train chaplains, how well does the final DACUM profile of a health care chaplain meet their needs and expectations?
    a. From the perspective of the CPE supervisors, who train chaplains, what are the strengths and weaknesses of the final DACUM profile?
    b. From the perspective of the CPE supervisors, who train chaplains, which are going to be the most difficult and the easiest components of the final DACUM profile to address in future training interventions?
        i. What challenges do the CPE supervisors anticipate implementing the final DACUM profile into future training interventions?

4. From the perspective of the curriculum development panel, how well does the final DACUM profile of a health care chaplain meet their needs and expectations?
    a. From the perspective of the curriculum development panel, what are the strengths and weaknesses of the final DACUM profile?
    b. From the perspective of the curriculum development panel, which are going to be the most difficult and the easiest components of the final DACUM profile to implement into a future curriculum?
        i. What challenges does the curriculum development panel anticipate implementing the final DACUM profile into a future curriculum?

Summary

A mixed methods case study approach, with an emphasis on qualitative methods, has been selected for this study exploring the health care chaplain role. The selected approach is well suited for investigating unique and complex cases in health and health care that are complex, such as the case with the role of health care chaplain (Fetters, Curry, & Creswell, 2013). The data included some basic quantitative statistics and qualitative data, primarily from DACUM panels, semi-structured interviews, and surveys.

I examined one cross-section of chaplains in the metropolitan New York City area, the majority of whom were affiliated with one organization (The HealthCare Chaplaincy Network) which currently partners with a number of health care institutions in the area and several cities across the United States. I investigated if the DACUM process, taught at Eastern Kentucky University, could be used to generate an accurate

occupational profile of the profession of health care chaplain. To ensure greater accuracy, two panels reached consensus on a profile that represents what health care chaplains do and need to know to function successfully in health care settings today. In addition, I assessed if a panel of curriculum developers and a panel of Clinical Pastoral Educators can use the profile to develop curriculum and deliver training for future learning interventions.

Chapter IV

DATA, FINDINGS, AND INTERPRETATIONS FOR RESEARCH QUESTION 1

Introduction

Beginning in mid-November 2014, data was gathered, validated, compiled and analyzed towards the development of a profile of a health care chaplain. Data collection was completed when the email responses from Panel 5 were received. The consensus of all 33 participants who either contributed to the development of the profile or assisted in reviewing or validating the profile helped to inform my analysis. After the first three panels, 1,643 photos were reviewed and were used to create a photo log (Appendix E) which was emailed to participants for comments. Over the months of data collection, digital audio recordings were created of all meetings for review and analysis. As a result, 48 hours of digital recordings were reviewed.

Each panel contributed their input during the time they met with me along with follow-up emails and telephone calls. To report the findings from each panel and address each research question, the data, findings, and interpretations for each research question will be reported over the next three chapters. Table 2 shows a mapping of panels to the research question, a brief description of the panel, the primary modality used for data collection, and the chapter where the data, findings, and interpretations are presented. I begin each chapter with a brief discussion of panel demographics. Then I restate each research question considering the appropriate panel's data. For example, since Research Question 1 is addressed by the data output from panel one, the elements of the profile

developed by panel one will be presented in Chapter 4. The findings, the method used for analysis, and my interpretation of the findings will be provided for each research question and sub-question.

Table 2

Panel Descriptions, Logistics and Panel to Research Question (RQ) Mapping

Panel	RQ	Description	Modality	Chapter
1	1	Initial Panel	In-Person	4
2	2	Validation Panel	In-Person	5
3	3	CPE Supervisor	In-Person	6
4	4	Curriculum Development	Web Conf.	6
5	2	Geographically Diverse Validation	Email	5

The outline of the data results and findings for Research Question 1 will be:

- Panel 1 Demographics
- Restate Research Question 1
- Research Question 1-Profile artifacts
- Panel 1 Overview
- Research Question 1 –Findings
    - Finding 1
        - Method of analysis
        - Data Supporting finding
    - Finding 1.0 Interpretation
    - Finding 2.0
        - Method of analysis

        - Data Supporting finding
    - Finding 2.0 Interpretation
    - Etc…(This is only a sample because each research question may have more than two findings.)
- Research Question 1a-Findings etc.
- Research Question 1b-Findings etc.
- Research Question 1bi-Findings etc.

I now present descriptive statistics based on frequencies regarding key Panel 1 demographics as compiled from the Demographics survey (Appendix C) and an introductory question asked on day 1 of the panel.

Panel 1 Demographics

Several key demographic descriptors were reviewed from the Demographic Survey because of their relevance to the research questions. These include Gender, Ethnicity, Age, Years as a Chaplain, Religious Affiliation, Ordination Status, Certification Status, Workplace Location, Title.

Of the nine participants on Panel 1, as shown in Table 3, twice as many were females as males. The majority (77.8%) of the participants identified themselves as white or Caucasian, while the panel's average age was 61 years old. All nine participants (100%) were ordained or had professed their faith according to the Roman Catholic rites. The majority of the participants (77.8%) were certified by one of the national certifying organizations. As to religious affiliation, less than half (44.4%) self-identified as a member in one of the Protestant organizations, while less than a quarter (22.2%) self-identified as Jewish or Roman Catholic, respectively. All nine participants served in

Table 3

Panel 1 Demographics Summary

	Panel 1 Participants (N = 9)	
Characteristics	N	Percentage
Gender		
Male	3	33.3
Female	6	66.7
Ethnicity		
Asian or Pacific Islander	1	11.1
Black or African American	1	11.1
White or Caucasian	7	77.8
Eastern European	0	0.0
Age Distribution		
25-34	0	0.0
35-44	1	11.1
45-54	2	22.2
55-64	2	22.2
65-74	3	33.3
75+	1	11.1
Years As A Chaplain		
No Response	0	0.0
2-5	0	0.0
6-10	3	33.3
11-15	1	11.1
16-20	1	11.1
20+	4	44.4
Ordination Status		
No Response	0	0.0
No	0	0.0
Professed	2	22.2
Yes	7	77.8
Certification Status		
No Response	0	0.0
No	2	22.2
Yes	7	77.8
Religious Affiliation		
Protestant	4	44.4
Jewish	2	22.2
Muslim	1	11.1
Roman Catholic	2	22.2

New York City area hospitals, though one chaplain worked in a Long Island hospital and a second in a hospital in Westchester County both of which were considered suburban facilities. The remaining chaplains served sites in the five boroughs of New York City-Manhattan, Bronx, Brooklyn, Queens or Staten Island. Two of the participants had the title of Director, while one self-identified as an Associate Director. The remaining six participants self-identified as staff chaplain.

Participants who spanned most age ranges, were certified and ordained and represented many of the mainstream religious organizations developed the profile. As a comparison, in a study of a cross-section of hospitals conducted by Cadge (2012) with 23 staff chaplains, 55% were males, and 45% were females, 83% were ordained, 52% were Protestant, 78% self-identified as White or Caucasian, with an average age of 53 years old. In 2010, the APC reported 75% of their members were certified, while the NACC reported 73% of their members were certified (Cadge, 2012). Cadge goes on to say that the available demographic data is unreliable because chaplains have not been studied systematically.

In summary, after reviewing the demographics of gender, ethnicity, participant age, participant experience, religious affiliation, ordination and certification status I concluded that I had a balanced representation that compared well to the study conducted by Cadge (2012). The only notable variation was my study had 21% more females and 21% fewer males represented than were reported in Cadge's study. The profile was developed by a diverse, experienced, blend of health care chaplains and it was representative of their vision of the role.

Next, I review the first research question that provided the foundation for my study of health care chaplains.

Research Question 1 Review

In fulfilling this study's purposes, I will answer the following questions:

1. From the perspective of the initial DACUM panel of health care chaplains, what are the competencies, i.e., duties, tasks, knowledge, skills, traits, and tools, identified for the role of health care chaplain?
    a. From the perspective of the initial DACUM panel of health care chaplains, what knowledge, skills, and tasks are identified as new worker training needs, and veteran worker training needs?
    b. From the perspective of the initial DACUM panel of health care chaplains, what are the most satisfactory, successful, and challenging aspects of the DACUM process?
        i. On the initial panel, how does race, gender, experience, and religious affiliation influence the health care chaplains' perception of what is satisfactory, successful and challenging?

Now that I have restated Research Question 1 and its associated questions, I will next present the artifacts that were produced by the first panel.

Research Question 1: Profile Artifacts

The profile of a health care chaplain that was developed by Panel 1 using the DACUM methodology consists of several key artifacts. This data provided the framework for my findings in response to Research Question 1 and its sub-questions. The artifacts that Panel 1 delivered at the end of the 3-day session were:

- Artifact 1: An initial job description
- Artifact 2: An initial, graphical, prioritized storyboard with duties and tasks
- Artifact 3: A rank ordering of duties per importance and based on the amount of time spent performing during a typical week
- Artifact 4: An initial, prioritized, list of concepts chaplains need to know to be successful
- Artifact 5: An initial, prioritized, list of skills chaplains need to have to be successful
- Artifact 6: An initial list of traits and tools chaplains need to have to be successful

Artifact 1: An Initial Job Description

The initial job description developed by Panel 1 was crafted based on the following four propositions: Who, What, How, and Why. The initial job description that Panel 1 delivered in its final form was the following.

> Professional health care chaplains, grounded in faith, enable people to access their spiritual/emotional resources in order to provide hope, comfort, and healing. Chaplains achieve this by doing a spiritual assessment, developing and implementing a care plan, measuring outcomes and providing documentation.

Artifact 2: An Initial, Graphical Storyboard with Duties and Tasks

The initial storyboard that was delivered consisted of nine duties and 60 tasks. Six of the duties had seven to eight tasks each while the remaining duties had six or less tasks each. The left side of the storyboard displaying duties and the first four associated tasks is shown in Figure I1 in Appendix I. The right side of the storyboard with the remaining tasks for each duty band is shown in Figure I2 in Appendix I.

Artifact 3: A Rank Ordering of Duties Based on Two Metrics

Two rank ordering exercises were conducted at the completion of the initial storyboard. The first exercise had the panel rank the duties in importance from most to least. The second exercise had the panel rank the duties according to the amount of time spent on each. These results, shown in Table 4, brought to light the impact of being a director and a chaplain has on one's priorities.

Table 4

Panel 1's Rank Ordering of Duties Based on Importance and Time Spent

Duty Band Identifier	Ranking based on Importance	Percent of time spent during work week	Duty Band Name
A	1	33.6%	Conduct Pastoral Visits
B	3	10.3%	Provide Education
C	5	8.3%	Provide Leadership
D	8	7.6%	Promote Pastoral Care
E	6	11.1%	Administration
F	7	5.7%	Facilitate Connections
G	8	4.6%	Professional Development
H	4	8.1%	Team Participation
I	2	10.7%	Triage Visits

Artifact 4: An Initial List of Concepts Chaplains Need to Know

Thirty-one items, shown in Table 5, were identified by Panel 1 as key concepts that health care chaplains must know to be successful. The highest number of labels

affixed to a knowledge concept was two for new worker training needs, and veteran worker training needs. Those concepts that two chaplains labeled were incorporated into a list of concepts that new workers need training in and veteran workers need training in and could be used in the prioritization of curriculum objectives. In Table 5, all knowledge concepts are represented with the number of labels applied by Panel 1 participants.

Table 5

Concepts Identified by Panel 1 that Health Care Chaplains Need to Know and Those Identified as Needed for New Workers and Veteran Workers

NW Training Needed	VW Training Needed	Knowledge Concepts
	1	Hospital chain of command
		Knowledge of differences
2		General understanding of other health care roles
2		Knowledge of other team members roles
1		Knowledge of other cultural traditions
		Bereavement theory
2		Medical terms
2		Knowledge of self
1	1	Deep knowledge of own faith traditions
1	2	Hospital policies and procedures
1		Boundaries
		Ethics
1		HIPPA
2		Theological grounding
		Stages of human development
2	1	Knowledge of hospital/institutional culture
		Substance abuse
1		What your job is NOT
1		Working knowledge of other faith traditions-protestant traditions
		Knowledge of Gods messengers (Knowledge of sacred texts)
		Community organizations
1		Triangulation

Table 5 Continued:

NW Training Needed	VW Training Needed	Knowledge Concepts
		Stages of faith development
		Knowledge of psychological systems
		Transference/counter transference
		End of life care/advanced directives
		Disaster training
		Palliative care principles

Artifact 5: An Initial List of Skills Chaplains Need to Have

Eighteen items, shown in Table 6, were identified by Panel 1as key skills that health care chaplains must have to be successful. The highest number of labels affixed to a skill was two for new worker training needs, and veteran worker training needs. Those skills that two chaplains labeled were incorporated into a list of skills that new workers need training in and veteran workers need training in and could be used in the prioritization of curriculum objectives. In Table 6, all skills are represented with the number of labels applied by Panel 1 participants.

Table 6

Skills Identified by Panel 1 that Health Care Chaplains Need to Have and Those Identified as Needed for New Workers and Veteran Workers

NW Training Needed	VW Training Needed	Skills
		Active listening
1	1	How to communicate in a crisis situation
		Communication skills
2		Develop relationships
	1	Think quickly on your feet
	2	Leadership

Table 6 Continued:

NW Training Needed	VW Training Needed	Skills
		Know when to refer
	2	Non sectarian prayer
	2	Self care
		Politicking inside institution (diplomacy)
		Computer skills
		Conflict management
		Mediation
		Articulation of faith traditions
		Leading ecumenical worship service
		Managing crisis situations to diffuse
		Transferable skills from previous jobs

Artifact 6: An Initial List of Traits and Tools Chaplains Need to Have

Panel 1 participants identified 25 traits and two tools as key to being a successful health care chaplain. In the language of DACUM traits and tools are considered enablers and are not part of the prioritization exercises. The traits identified by Panel 1 that health care chaplains need to be successful were of two categories; those that were generic traits and those that were religious traits. The generic or behavioral traits were intuitive, resilient, patient, joyful, sense of humor, compromise, flexible, assertive, self-confident, persistent, has a strong stomach, reliable, has a positive outlook, and humorous. The religious traits that were identified were pastoral identity/authority, faithful, hopeful, personal spiritual life, speak the truth, grounded in own theology, creates a safe space, enables others to experience hope and meaning, and understands relationships and how they impact the patient.

The tools identified by Panel 1 consisted of only two items - a Rolodex and a Referral List.

Now that I have reviewed the artifacts that panel one delivered I now present a brief overview of Panel 1 and my eight findings.

Panel 1 Overview

Panel 1 was scheduled to begin at 9:30AM but did not begin until almost 11AM because of travel delays that all participants experienced. One notable delay was the result of a flooded tunnel on the number six subway, which forced several participants to leave the subway and resort to walking downtown as part of a very unpleasant Monday morning commute. When we got underway, I had eight highly intelligent, articulate, caring and vocal participants in the room. Chaplain C1 was only able to participate on the first day, while chaplain C4 was not able to join until the second day. Chaplain C6 had to leave early on day 3 and was not able to contribute to the ranking and prioritization exercises. Despite the weather, the darkness as pointed out by chaplain C11, and the scheduling modifications, the panel had eight interested participants consistently throughout the proceedings.

Once we started and I explained the purpose of this study, everyone's energy was up. I came away from Panel 1 knowing they had produced a profile for going forward.

Now I present a list of my findings for Research Question 1 and it's three sub-questions.

Research Question 1: Findings

The following are my findings that pertain to Research Question 1. The reason why each of these findings became notable will be explained later in this chapter.

1. No religion specific duty band was requested or found on the storyboard.
2. A chaplain is more than what they do; a chaplain is more than a list of tasks.

3. Of the nine duties and 60 tasks defined on the storyboard by the Panel 1 chaplains, traditional sacred language was incorporated in 15% of the tasks.
4. Of the nine duties and 60 tasks defined on the storyboard by the Panel 1 chaplains, 16.7% of the tasks were flagged as Critical to the role by two or more participants.
5. There are gaps in what chaplains do and what CPE has provided in the way of training.

Research Question 1a: Findings

6. Less than 20% of tasks, knowledge concepts, and skills were identified by two or more Panel 1 participants as elements requiring new worker training or veteran worker training.

Research Question 1b: Findings

7. Panel 1 participants found the DACUM process to be a satisfactory, successful, and challenging process.

Research Question 1bi: Findings

8. Race, gender, and experience did not influence the health care chaplains' perception of what was satisfactory, successful, or challenging.

For the remainder of this chapter I examine each of these findings, one-by-one, the methods used for data analysis, the data supporting the finding, and my interpretation of the finding and its' data. I begin by examining the five findings associated with Research Question 1 starting with Finding 1.

Finding 1: Method of Analysis and Data

No religion specific duty band was requested or found on the storyboard.

Method of Analysis

This finding was a constant theme throughout the first panel. The theme first was discussed on day 2 of Panel 1 after we had concluded the duty exercise, which is known as the duty dump. I had mentioned the emergence of one obvious theme, leadership, but asked if we needed to capture religion specific duties. I made note of this conversation in my end-of-day memo, my end-of-panel memo, and my end-of-week memo. Because this is the exchange where the decision was made not to have duty bands that were oriented by religious affiliation, it becomes a source for this finding. The list of nine duties as proposed by Panel 1 can be seen in the two Figures I1 and I2 shown in Appendix I.

It is noteworthy that outside of the word Pastoral used in two different duties, no mention is made of a religious group. The following interaction provides the data that supports this finding.

> Facilitator: A lot of what I'm seeing up here in the duty dump is interfaith or multifaith oriented… One theme that I've seen surface is leadership whether it be chaplaincy leadership with a director, nevertheless it is leadership. But, what I haven't heard you say is something specific to your own faith tradition. What is it that you do that makes you unique to your tradition as a chaplain? Should we capture that? As a Roman Catholic, as a Muslim, as a Jew, as a Baptist, as a Presbyterian?
>
> C6: That's complicated, I think that's a very complicated question you guys my impression is that the field is trying very hard to speak Esperanto! We are trying very hard to create a vast world of multifaith chaplaincy. And faith specific chaplaincy is not in fashion currently…

C6: I think the hospitals want us to have our own faith tradition but not advertise it. Around the high holy days for the Jewish chaplains and Hanukkah, hospitals want us but not to be too Jewish. We should be welcoming all which means we have to take our identity and push it to the back.

C4: I work out of my faith tradition I can't do anything but I'm a Muslim and I'm gonna come from the Islamic perspective. I can't separate the two I want to come and I'm gonna work as a Muslim in a health care setting.

Facilitator: Do we need to capture this?

C4: I think we need to capture this as a Muslim in the Muslim tradition there are many faith traditions and if I have to operate within a health care setting, it needs to be captured. By visiting a Catholic patient and the lady asked me to pray for her to die I can't do that I just can't do that. It goes against my faith tradition.

C8: Neither can the priest!

C4: In my faith tradition, I can't pray for her to die because this is my faith tradition.

Facilitator: What would be a general area of competence or duty that would be specific to the Muslim faith, or the Jewish faith, or the Catholic or to any of the Protestant faiths that we need to get on the board? Or, should we just go with what we have?

C8: No I think that's gonna come under the knowledge skills and traits and abilities.

Facilitator: So what I'm hearing is that we don't need a separate duty for each faith tradition. Is that correct? C9? C12?

C9: We highly respect the dignity and the religious rights of the patient. If the patient wants an imam, we will get them. We know most patients are spiritual though they are not religious.

C4: I was hired as a Muslim.

Facilitator: So a more holistic view of chaplaincy would work for you as well is that correct?

C4: Yes, it will.

C8: To be a professional chaplain you have to work both sides. You have to come from both sides to be certified you have to come as an endorsed, ordained, representative of your own faith tradition and you have to be able to interact with those of other faith traditions.

C11: I've got the patient first and foremost in view. That informs our own faith tradition so we are there for the patient; that's what's most important and often tradition informs how we should see, how we will interact with them, but the patient is the most important goal for us.

Facilitator: So we're gonna build a profile that is more or less holistic correct?

C8: We don't necessarily need to have more duties specific duties based on tradition. It is already spelled out under knowledge - knowledge of our own faith tradition and knowledge about other traditions that should be sufficient we need to watch the language that we use in the profile. We work as generalists and those things we share but we also work for particular interests and those things we have to do uniquely for our own tradition.

Facilitator: So we are good. Can I get an Amen from the congregation?

All Chaplains: Amen!

Finding 1: Interpretation

I came into this study assuming that each chaplain would want to have his or her religious affiliation documented as part of the profile. I thought in particular, the Jewish rabbis, and the Roman Catholic priests and nuns would insist on separate duty bands to include their rites, rituals, and ceremonies. My assumption was proven incorrect. Health care chaplaincy in this day and time is now, based on this panel's profile, an interfaith role. As chaplain C8 stated, "We work as generalists and those things we share but we also work for particular interests and those things we have to do uniquely for our own tradition." The profile developed by the Panel 1 chaplains is a holistic profile of a health care chaplain. Whether this profile was an accurate representation of all health care chaplains required validation by the other panels.

Finding 2: Method of Analysis and Data

A chaplain is more than what they do; a chaplain is more than a list of tasks.

Method of Analysis

This finding was a persistent theme throughout the first panel. It first was discussed on day 2 of Panel 1 after we had concluded the initial building of the storyboard and the final job description was agreed on. The final agreed up job description is shown in Artifact 1. The major point of discussion over the three days of this panel was how a professional health care chaplain "enables people to access their spiritual/emotional resources in order to provide hope, comfort, and healing." The final agreed upon language was, they "achieve this by doing a spiritual assessment, developing and implementing a care plan, measuring outcomes, and providing documentation." This

agreed upon language came right out of Duty Band A: Conduct Pastoral Visits which was the first duty band developed by the panel, and is shown in Figure I1 and Figure I2 in Appendix I. The job description developed by Panel 1 was a reflection of five tasks in Duty Band A: conduct a spiritual assessment, develop a care plan, implement a care plan, measure outcomes, and provide documentation. These tasks, though unanimously agreed to, generated discussion. Several chaplains, like chaplains C4 and C6 thought the language was "too clinical." Others like chaplain C8 thought it was a good representation of a trend in modern health care chaplaincy, namely "outcome oriented chaplaincy." In Panel 1, the outcome oriented philosophy was accepted for the job description. I discovered quickly this group of experienced chaplains were not quite through with the concept of a job description.

We were getting ready for a short break, when chaplain C9 shared a milestone insight. We needed to capture not only what a health care chaplain does but also what a chaplain is. I shared a quick story of my parents experience with effective health care chaplains, which is omitted below followed by an ad hoc homework assignment. It was immediately apparent by the sidebar discussions that were going on that this was of importance to every panel member. I made note of this conversation in my end-of-day memo, my end-of-panel memo, and my end-of-week memo. Since the following exchange is the point where the decision was made, to not only capture what a chaplain does, but what a chaplain is, it provides the data that supports this finding.

> C9: I'd like to see us come up with the definition of who we are as a chaplain not just the job description but something that describes our qualities. It's more than a job description we are the chaplain.

Facilitator: Okay my question to you then is what is a chaplain? Don't give me a list of bulleted traits, but put it in a paragraph form. That's your homework for tonight. You will each present your description in the morning. Everyone agree?

All panelists: Yes

C7: It's interesting to hear you talk about the chaplain visits with your parents how they didn't have to be deep, but they could be talking about the old neighborhood. It's also very interesting to hear especially since we expect our chaplains to evoke a very deep motivating conversation, and it's not always necessary. Thank you for sharing that Warren.

Facilitator: Thank you. Let me follow up with a few questions that might help as you consider your homework assignment. What are the three things that you need to have a trusting relationship with someone? What does it mean for you to be a good chaplain? What does it mean for you to be a chaplain? What are the qualities and attributes that you need, that you feel are most important to be a chaplain and this is for all of you here, not just C7.

C6: May I ask a question?

Facilitator: Sure.

C6: Is this process about what a chaplain does or who a chaplain is?

Facilitator: What a chaplain does, but if we have 5 minutes to research a question that seems to be on everyone's mind it's important to explore it and capture that as well. That's why I'm asking you to consider what a chaplain does and what a chaplain is.

C6: It's interesting to think that CPE students take away from CPE thinking that they know what a chaplain does know and what chaplain is. One discovers what they are bringing to the table. They don't really learn with this stuff any of this that we're discussing today.

Next morning:

Facilitator: Now we have a working job description that all of you have contributed to. It took a lot of effort to get here but we made it. Now we have an outstanding assignment from last night. Before we finish up the storyboard, tell me what is a chaplain?

C12: Warren thank you for this exercise. That is my whole discomfort about this process you're talking about what we do, not who we are as chaplains, and I needed to reflect on who I am not just what I do. A good part of being a hospital chaplain is who you are not just what you do!

Facilitator: Well said C12. This is the unofficial part of this process so what is a chaplain not what do you do? ... So what are you?

C12: I couldn't do this without some theological reflection. As a chaplain, I am a gifted, graced, fragile, wounded human being called to participate in God's work of healing in our health care community. I embody the presence, love and compassion of God (humanity at its best) as well as that of our Muslim, Jewish… (human) community. I strive to create a safe, sacred space in which the person can tell their story and move toward connecting it to our sacred story. (one universe's healing energy meaning and hope)

C10: I am friendly, compassionate, and a good listener

C9: I am a professional, certified chaplain, who evokes and enables in a sacred space someone to get in touch with the spiritual and emotional needs of the people I meet. As a professional certified chaplain, I partner with physician and staff to evoke the spiritual/emotional needs of patients, families and staff.

C7: The chaplain is someone who creates a sacred space, ministers to people of all faiths or no faith, by using their inner resources. They are somebody who can help someone through difficult times in a safe, caring, nonjudgmental way. That's what I try to do.

C6: A chaplain is patient, intuitive, and grounded in their own theology, knows how to use humor and create a sense of space to help people feel safe and helps people to identify glimmers of hope and meaning in their experience. A chaplain is someone who cares about and understands relationships, family and otherwise, and sees how they impact the patient; believes that their work is sacred and vital to a patient's health.

C4: A chaplain embodies the mind, body, and spiritual connection of the earthly experience of the human being, utilizing self as a living document to receive and give back what is innately in all of us, our good humanity. The awareness and acceptance of the presence of God in my life. I follow in the footsteps of God's prophets and message and how their life example impacts my life today. Hardships, illness and death are an integral part of our existence. I walk with my family, patient and their family and community in places of fear in which I bring hope, comfort and God's presence.

C11: It seems like we're a bunch of blind folks all sitting around and describing what an elephant is.

< laughter a lot laughter>

Facilitator: Nice. Now a chaplain is….

C11: A chaplain is someone who is spiritually and emotionally grounded, theologically trained, culturally astute and embodies humor, resilience, grace, joy, curiosity, compassion and hope in ministering to the spiritual needs of patients, families and staff.

C8: A chaplain is an ordained minister professionally trained to help others find hope and purpose in the midst of crisis in order to meet the challenges of the crisis they face.

Facilitator: WOW! This helps a lot. Any final thoughts on what a chaplain is or the job description-what a chaplain does?

C6: This new job description actually helps me because when I went into CPE this is not what they actually showed me but this is what I did with the patients. This is very helpful for future chaplains!

Facilitator: Thank you. Anyone else? … No? Okay, let's finish up the storyboard.

To graphically display this theme and to extract the major themes, I pasted this conversation into a Word Cloud Generator after removing the identifiers, such as C11, and the word chaplain. The resulting graphic is shown in Figure 3. Some secondary themes that are shown are sacred, hope, people, space, presence, and spiritual.

Figure 3. Word Cloud Showing Major Themes Resulting from Panel 1 Interaction Over the Question, What is a Chaplain

Finding 2: Interpretation

This exchange between the chaplains was enlightening. Despite what they said a health care chaplain does in the job description or on the storyboard the dominant theme that emerges from their description of what a chaplain is, is a God-oriented person. Based on this discussion by the Panel 1 chaplains, that chaplains are God-oriented, spiritual people who offers others hope by their presence and by offering them a sacred space. As

chaplain C12 concisely said, “A good part of being a hospital chaplain is who you are not just what you do!”

Finding 3: Method of Analysis and Data

Of the nine duties and 60 tasks defined on the storyboard by the Panel 1 chaplains, traditional sacred language was incorporated in only 15% of the tasks.

Method of Analysis

The analysis was conducted in four steps. First, I reviewed the storyboard for frequency of occurrence of each sacred term and derivatives of the terms. Second, I noted the tasks where sacred terms were used. Third, I noted the duty bands where the sacred terms were used. Fourth, I reviewed excerpts from three discussions. The first discussion I took note of was an anecdote provide by C10 during her introduction to the panel where she described a conflict with her CPE Supervisor over the use of the phrase *Almighty God*. The second discussion revolved around the term prayer and chaplain C4’s insistence that it be included on the storyboard. This second discussion helped to define this panel’s passion for what they do. The third discussion was the closing prayer offered by chaplain C4 and requested by every member of the panel. This closing prayer helped to solidify for me the dialectic that is the current role of a health care chaplain.

The following frequency data, and three interactions provides the data that supports this finding.

The terms *spiritual, pastoral, religious,* and *prayer* occurred 12 times on the storyboard; two times in duty band labels, and in nine unique tasks. Fifteen percent of the tasks used one of these four sacred terms. The words clergy and chaplain were not

considered sacred for the finding, since they are terms that define an occupational role that might be found on a nurses' or social worker's storyboard.

The word *spiritual* occurred in four tasks. A2: Conduct spiritual assessments; B5: Provide ongoing spiritual/religious staff education; C2: Serve as a resource and point person for moral, ethical, and spiritual issues; D6: Represent spiritual/emotional needs on teams, committees and programs.

The word *pastoral* occurred in four tasks: A1: Establish pastoral connection; C1: Conceptualize vision for pastoral care that supports and enhances the institutional mission; D2: Establish working partnerships with key physicians and other decision-makers who understand the value of pastoral care; E2: Ensure timely and appropriate delivery of pastoral care.

The word pastoral also occurs in two of the duty identifiers, A: Conduct Pastoral Visits, and D: Promote Pastoral Care respectively. These labels were not included in the analysis for Finding 3 because they were not specific tasks identified by Panel 1 but a high-level description of a group of tasks.

The word *religious* occurs in one task. It should be noted that this task also contains the word spiritual. B5: Provide ongoing spiritual/religious staff education

The word prayer occurs in one task. C5: Initiate and/or lead prayer

Two of the tasks, A1 and A2, occurred in the Conduct Pastoral Visits duty band. One task, B5, occurred in the Provide Education duty band. Three of the tasks, C1, C2, and C5, occurred in the Provide Leadership duty band. Two of the tasks, D2 and D6, occurred in the Promote Pastoral Care duty band. One task, E3, occurred in the Administration duty band.

Three Interactions:

The following are the three interactions that made this a noteworthy finding.

Interaction 1:

C10: In the book of Timothy, it says a woman cannot teach. My church is the Korean Presbyterian church, which follows this teaching. So I had to ask what is Gods calling for me?

Facilitator: Go on.

C10: In my first unit of CPE, when doing my verbatim, we had to speak our prayer as well, and I said Almighty God, and the supervisor and everyone in the unit attacked me! Almighty God was not proper to use. We have to be interfaith, so I asked is Almighty God bad? Even my supervisor said don't use that. So I thought if I can't use Almighty God, I'm not going to do this. So I stopped for 4 years I didn't go back to CPE and chaplaincy until 2004. In 2004, I went back to New York Hospital and CH and I had a new supervisor who told me it was okay to use Almighty God.

Interaction 2:

On Day 2, in the early afternoon while populating the Provide Leadership duty band, the following interaction was noted.

C4: We don't have prayer up there anywhere do we?

C6: No! Prayer is not on the board at all.

C10: I think prayer should be under conduct pastoral visits.

C4: No!

C10: The patient requested, petitioned the prayer during a pastoral visit.

C4: Prayer period! Not just during a pastoral visit. Now, I'm just speaking for myself. I am mentioning prayer because, as a Muslim, I am considered the leader of prayer. That is our title.

C8: I would see that as leading worship.

C7: I agree it is part of leading worship. Like leading prayers at a hospital dinner or in some sort of conference or something like that.

C8: That would be more like team participation wouldn't it?

C4: When you're in with a group of family members or something like that they need somebody to lead them in many cases and sometimes this is leading them in prayer. My title is imam means leader of prayers.

C8: I think you're kind of hung up on the word.

C4: In Islam some don't even know how to lead the prayer so we have to be sure we are leading the prayer and that's part of our leadership as a chaplain.

Facilitator: Here's a question for you. Is prayer a task that has a definite beginning and ending and leads to some product, service, or decision, and I ask this of each of you.

Everyone: YES! it is when you say ask it like that it is a task.

Facilitator: So give me the language.

C4: So some of our patients don't know how to pray so we have to lead them in prayer.

C6: Maybe the language is just pray.

C4: Maybe we just say initiate and or lead prayer. We have to make sure the language is inclusive, not exclusive to just Islam.

C12: I'm in agreement with you C4. Thank you.

Interaction 3:

This is the closing prayer for the 3-day panel offered by C4 and requested by all other participants.

C4: With God's name the merciful benefactor the merciful redeemer dear God we thank you for allowing us to be here today for this wonderful opportunity to establish a curriculum for our discipline. We thank you for our leaders who provided this place for us to allow us to do this work. We thank you for all those who worked so diligently to make this come about and above all we thank you for the camaraderie of those who are here knowing that we do the best we could do to bring about this information to our communities and the people. Bless the sick and the weak following this country and all over the world, wherever they may be. Take care of us and provide us with the best going forward in our discipline. This we pray. Amen.

Facilitator: And all God's children said AMEN!

Everyone: AMEN! Thank you!

Finding 3: Interpretation

What Panel 1 developed for a storyboard, shown in Figure I1 and Figure I2, had a few surprises. The one surprise that Finding 3 is based on is the limited number of times that traditional sacred language is used. Terms such as spiritual, pastoral, derivatives of the word religious, and the word prayer only occur in nine tasks on the storyboard. The words God, Lord, YHWH, Messiah, Savior, Allah, or Jesus did not occur one time.

Health care chaplains are having to live in two worlds; the world of modern medicine where they function in primarily an interfaith capacity, and the world of the sacred representing their religious tradition (Cadge & Sigalow, 2013). For some, like chaplains C4, C6, and C12, the two worlds are one. For most of the other panelists, based on the limited use of traditional sacred terms, the role of health care chaplain is evolving into a secular role within health care whose focus is outcomes as evidenced by task A5-Measure Outcomes. Despite this evolution, every chaplain on the panel expressed his/her appreciation for chaplain C4's fervor for including a task (C5) under the Provide Leadership duty that included the word prayer. There was a rigorous, passionate discussion, but chaplain C4 was speaking a language that all chaplains identified with as evidenced by Finding 2, but were hesitant to include on the storyboard. The panel's appreciation for chaplain C4's passionate stance became clear as we were wrapping up the third day. Every chaplain asked C4 to offer a closing prayer. He agreed and extemporaneously offered a beautiful example of a prayer that Catholic chaplains, Jewish chaplains, and Protestant chaplains could embrace.

One possible reason for the limited use of sacred terms is the movement in health care chaplaincy towards a fully articulated interfaith model (Abu-Ras & Laird, 2011; Cadge & Sigalow, 2013). In this model, a chaplain of one religious tradition must respond to the needs of the patient no matter if the patient's background is the same as the chaplain or diametrically opposed, or is an espoused atheist. In this model, a chaplain must be able serve patients of all religious traditions, and patients who have no religious allegiance but must not offend any person, including their administration, while staying

true to their own religious heritage. As Abu-Ras and Laird (2011) discuss the interfaith approach is a one-size-fits all approach to chaplaincy.

Despite the clinical nature of the role of health care chaplain, and the limited use of traditional sacred terms on the storyboard, one should not overlook the sacred foundation from which a chaplain evolves and the daily tightrope each must navigate in order to serve.

Finding 4: Method of Analysis and Data

Of the nine duties and 60 tasks defined on the storyboard by the Panel 1 chaplains, 16.7% of the tasks were flagged as Critical to the role by two or more participants.

Method of Analysis

One of the first steps of the prioritization exercise is to have participants place a red label on tasks they individually deem as critical to their role. They do this quietly and independently, as discussed in Chapter 3. Only seven of the panelists could participate since one, chaplain C6, had to leave early at the end of day 3. Each chaplain was given six red labels to distribute over the storyboard.

The analysis was conducted in four steps. First, I reviewed the storyboard for frequency of occurrence of each task identified as critical by one participant. Second, I noted the tasks identified as critical by two or more participants, shown in Table 7. Third, I noted the duty bands where the critical tasks identified by two or more participants were used. Fourth, I totaled the number of red labels assigned to each duty band. Only those tasks flagged by two or more labels were noted for this analysis in an effort to address any special interest bias. For example, one chaplain who was also a

director placed a red label on an Administration task that was clearly important to her but not to any other staff chaplain. That was the only red label placed on a task in the Administration duty band. This process helped me to identify a central theme that is critical to the role of health care chaplain.

Table 7

Ten Tasks Identified by Two or More Panel 1 Participants as Critical to the Role of Health Care Chaplain

Task Identified	Duty Band	Number of Participants
A2- Conduct Spiritual Assessments	Conduct Pastoral Visits	4
A7- Document Visits	Conduct Pastoral Visits	4
A1- Establish Pastoral Connection	Conduct Pastoral Visits	3
H2- Interact with interdisciplinary team(s)	Team Participation	3
I3- Conduct Referred Visits	Triage Visits	3
B7- Mentor CPE and other students	Provide Education	2
A3- Develop Care Plan	Conduct Pastoral Visits	2
D2- Establish working partnerships with key physicians and other decision makers who understand the value of pastoral care.	Promote Pastoral Care	2
B4-Lead staff orientation	Provide Education	2
C2-Serve as a resource and point person for moral, ethical, and spiritual issues	Provide Leadership	2

The following data supports this finding. Seventeen tasks were identified critical and only received a single red label. As shown in Table 7, 10 tasks, 16.7%, received two

or more red labels. Of the 10 tasks receiving two or more red labels, the top three tasks came from the Conduct Pastoral Visits duty band receiving 25% of all red labels. The Conduct Pastoral Visits tasks received 48% of the red labels placed on tasks receiving two or more red labels. The duty band receiving the next largest number of red labels, 13.6%, was Team Participation, which had one task receiving two or more red labels.

Finding 4: Interpretation

In reviewing the results of the critical tasks portion of the prioritization exercise the main takeaway was four of the seven tasks in the Conduct Pastoral Visits duty were the most critical to the role of health care chaplain according to this panel of chaplains. To see that three of the tasks, A2 - Conduct Spiritual Assessments, A7 - Document Visits, and A1 - Establish Pastoral Connection received 25% of all red labels reinforced this panel's position on the importance of tasks involved in Conducting Pastoral Visits. Secondarily, this finding supports what the panel defined in the second half of their job description shown in Artifact 1 where they say,

> Chaplains achieve this by doing a spiritual assessment, developing and implementing a care plan, measuring outcomes and providing documentation.

Finding 5: Method of Analysis and Data

There are gaps in what chaplains do and what CPE has provided in the way of training.

Method of Analysis

This finding was an undercurrent throughout the 3-day panel. On day 1, while going through the initial development of knowledge concepts, skills and traits the idea of leadership training was mentioned in passing but not fully explored. On day 2, as the

storyboard was in its initial phase of development, a brief exchange occurred which I noted in my daily memos during which chaplain C6 shared a perceived gap in CPE, which I also noted. Finally, during a break on the afternoon of day 2, chaplains C6 and C8 had an interesting discussion about the variability in the curriculum from one unit of CPE to another. This was discussed in a manner so others could contribute but only C6 and C8 discussed this subject. Since this directly addressed one of the purposes of this study, I was keenly tuned in to their exchange and took notes.

To validate these three brief conversations, I examined the tasks that were flagged during the prioritization exercise as tasks not prepared for by CPE. These tasks, the number of participants who flagged them, and the duty band which owned them are shown in Table 8.

The tasks not prepared for by CPE shown in Table 8, and the following interactions provide the data that supports this finding.

Table 8

Nine Tasks Identified by Two or More Panel 1 Participants as Tasks Not Prepared for by CPE

Task Identified	Duty Band	Number of Participants
A5-Measure Outcomes	Conduct Pastoral Visits	5
A2-Conduct Spiritual Assessments	Conduct Pastoral Visits	5
E6-Conduct annual performance reviews	Administration	4
E7-Create and negotiate department budget	Administration	3

Table 8 Continued:

Task Identified	Duty Band	Number of Participants
G6-Participate in Performance Improvement and Quality Improvement	Professional Development	2
C7-Conduct crisis intervention and debriefing session	Provide Leadership	2
D2-Establish working partnerships with key physicians and other decision makers who understand the value of pastoral care.	Promote Pastoral Care	2
H2-Interact with interdisciplinary team(s)	Team Participation	2
A3-Develop Care Plan	Conduct Pastoral Visits	2

Interaction 1:

This first interaction occurred on day one and briefly explored whether CPE should train chaplains to be leaders and/or managers.

C12: A piece of what CPE does not prepare chaplains for is the managerial aspect.

C6: Leadership is not a trait that we foster in our chaplains. I took issue with it when we put it on the list of traits.

C8: CPE only trains you to be a staff chaplain it does not train you in management.

C6: I would include leadership also, not just management but also leadership

C10: We also need leadership we lead by helping others including staff families and patients.

C8: Some come right out of CPE and become directors immediately. CPE needs to have leadership and management as part of the curriculum.

C9: I was called in to negotiate with the administrator a budget for the department with no training.

Interaction 2:

On day 2 as we were beginning to populate the storyboard, chaplain C6 shared the following CPE experience with the other chaplains.

C6: I would like to say that in seven units of CPE no one ever told me the differences in the various Protestant religions. This was assumed that everyone knew the differences. We had a course on being a Jewish patient. We had a course a on being a Muslim patient, but never one on the differences between Christian patients.

Interaction 3:

On day two during a break the following conversation occurred between chaplains C6 and C8 regarding curriculum standardization.

C6: My first two CPE experiences were dramatically different. The first was quite therapeutic asking me how I felt about my mother. The second was more concrete here's how we pray with this type of patient. Here's how we work in the hospital. Here is how the hospital works. As someone who is an educator I was dramatically taken back at the differences in the curriculum between the first experience and the second experience. It took me aback. I am an adult I've been in therapy awhile. I don't need to talk about my mother here. There were many different messages between the two experiences.

C8: That is one of the benefits of having the chaplaincy department integrated into CPE. Staff chaplains can help you navigate the issues in the hospital without dealing with the stuff of CPE.

C6: That is one of the reasons why there has to be some standardization in the curriculum. If you teach American history in high school even if you have interest in only the tip of a specific topic, you still have to present the whole curriculum. You can't just go off on your own. Different experiences is different than having different content. You need to have the same standardized content across the all courses all deliveries.

C8: My memory of my initial CPE is kind of fuzzy since it was so long ago. As I became more of the seasoned chaplain and administrator, it became clear what he had to offer our students as part of the curriculum and what we didn't have to offer our students as part of the curriculum.

C6: What we didn't have to offer our students as part of the curriculum is just as important as what we offer our students.

C8: I was less concerned about that since I was not here as a CPE supervisor but more as an administrator or director. I came out of education as an educator. Once a teacher always a teacher! When you look at any kind of advanced training you always have to weigh the positives and negatives. For me I like the variability the flexibility of being an administrator and a chaplain as opposed to being a CPE Supervisor. So, the more you know who you are and who your mother was <laughter> the more you can figure it.

Finding 5: Interpretation

Based on these three excerpts and the tasks flagged as not prepared for by CPE, it is easy to deduce that there are gaps in what chaplains do on a day-to-day basis and the training received during CPE units. Fundamentals of leadership and management training must be provided if chaplains may also have to direct a department. If chaplains are expected to be multi-faith or interfaith professionals, CPE must ensure that all practitioners have a base level of understanding of the faith traditions they will serve. For rabbis not to have received training in the differences between Protestant traditions is unacceptable. To paraphrase chaplain C6: If you teach CPE in New York City, even if you have interest in only part of a topic like pediatric oncology, you still have to present the whole curriculum. You cannot just decide that a student's experience can only revolve around pediatric oncology when the student might also want to learn how to care for older citizens. You need to have the same standardized content across all deliveries of CPE. Therefore, the whole problem with CPE is there is no truly standardized program called CPE with a standardized curriculum. Until such an accepted curriculum is available, there is no way to gauge whether a student chaplain is prepared to serve in the role of staff chaplain.

What stands out to me is the fact that three of the tasks flagged by the Panel 1 chaplains as not being prepared for by CPE come right out of Duty Band A: Conduct Pastoral Visits and from the final job description developed by the panel. It should also be noted that Duty Band A: Conduct Pastoral Visits is the same duty cited in Finding 4 that contained the tasks found to be most critical to this role. The question that must then be addressed by those leading CPE, if practicing chaplains are indicating that CPE did

not prepare them to conduct a spiritual assessment, what is the quality of care being provided to patients by chaplains?

Research Question 1a: Findings

Finding 6: Method of Analysis and Data

Less than 20% of tasks, knowledge concepts, and skills were identified by two or more Panel 1 participants as elements requiring new worker training or veteran worker training.

Method of Analysis

One of the steps of the prioritization exercise is to have participants place a green or yellow label on tasks, knowledge concepts, and skills they individually believe require training for new or veteran workers respectively. They do this quietly and independently as discussed in Chapter 3. Only seven of the panelists could participate since one, chaplain C6, had to leave early at the end of day 3. Each chaplain was given six green labels to distribute over the storyboard, the lists of knowledge concepts and skills for the elements the panelist thought new worker training was needed. The same process was followed for veteran workers using yellow labels.

The analysis was conducted in four steps. First, I reviewed the storyboard and the lists of skills and knowledge concepts for frequency of occurrence of each element identified by at least one participant indicating new worker training or veteran worker training required. Second, I noted the tasks identified as requiring new worker or veteran worker training by two or more participants, shown in Table 9. Third, I totaled the number of green and yellow labels assigned to each list and the storyboard. Only those tasks flagged by two or more labels were noted for this analysis to address any special

interest bias. Then I calculated frequencies based on all tasks, all knowledge concepts, and all skills. The calculated frequencies are summarized in Table 10. Fourth, I noted the duty bands where the new worker training and veteran worker training tasks identified by two or more participants, also shown in Table 9. The following data supports this finding.

There were 17 tasks on the storyboard that were flagged by at least one chaplain as requiring new worker training, and 19 tasks were flagged by at least one chaplain indicating veteran worker training was required. When reviewing the list of tasks only nine were selected by two or more participants, and no task was selected for both new worker training and veteran worker training required by two or more participants, as shown in Table 9.

Table 9

Nine Tasks Identified by Two or More Panel 1 Participants Requiring New Worker or Veteran Worker Training

Task Identified	Duty Band	Participants for New Worker Training-N	Participants for Veteran Worker Training-N
A1-Establish Pastoral Connection	Conduct Pastoral Visits	0	3
A2-Conduct Spiritual Assessments	Conduct Pastoral Visits	1	3
A5-Measure Outcomes	Conduct Pastoral Visits	1	2
C1-Conceptualize vision for pastoral care that supports and enhances the institutional mission	Provide Leadership	0	2

Table 9 Continued:

Task Identified	Duty Band	Participants for New Worker Training-N	Participants for Veteran Worker Training-N
C7-Conduct crisis intervention and debriefing session	Provide Leadership	2	0
E3-Ensure chaplain understands responsibility in hospital structure	Administration	1	2
G7-Contribute to the field through conducting research, teaching and publications	Professional Development	1	2
H2-Interact with interdisciplinary team(s)	Team Participation	1	2
H3-Serve on system-wide committees, such as ethics and IRBs	Team Participation	2	0

There were 31 total concepts identified on the knowledge list of which 14 were identified by at least one participant indicating new worker training was needed and four were identified by at least one participant indicating veteran worker was needed. As shown in Table 10, six of 31 concepts (19.4%) were flagged by two participants for new worker training needed while only one concept (3.2%) was flagged by two participants for veteran worker training needed.

The six concepts flagged by two participants for new worker training needed were General understanding of other health care roles, Knowledge of other team members roles, Medical terms, Knowledge of self, Theological grounding, Knowledge of hospital/institutional culture.

The one concept flagged by two participants for veteran worker training needed was Hospital policies and procedures.

There were 18 skills identified of which two were identified by at least one participant indicating new worker training was needed and four were identified by at least one participant indicating veteran worker was needed. One of 18 skills (5.6%) was flagged by two participants for new worker training needed while three skills (16.7%) were flagged by two participants for veteran worker training needed.

The one skill flagged by two participants for new worker training needed was Develop relationships. The three skills flagged by two participants for veteran worker training needed were Leadership, Self-care, and Non-sectarian prayer.

Table 10

Percentage of Tasks, Knowledge Concepts, and Skills Identified by Two or More Panel 1 Participants as Elements Requiring New Worker Training or Veteran Worker Training

Element	% of Element Requiring New Worker Training	% of Element Requiring Veteran Worker Training	Number of Elements NW/VW
Tasks	3.3%	11.7%	2 / 7
Knowledge Concepts	19.4%	3.2%	6 / 1
Skills	5.6%	16.7%	1 / 3

Of the nine tasks on the storyboard that were flagged by two or more participants from Panel 1as requiring new or veteran worker training, only two tasks were selected by three participants. The two tasks were from the Conduct Pastoral Visits duty band as shown in Table 9, and were flagged for Veteran Worker Training required. These were the only two elements to receive three or more labels from the participants of Panel 1.

Finding 6: Interpretation

My impression from data collected for Research Question 1a is the participants from Panel 1 did not have a consistent position on which tasks, concepts, and skills required training for new workers or veteran workers. The only two elements that more than two chaplains flagged for veteran worker training were the first two tasks of the duty band A: Conduct Pastoral Visits. This finding is in line with Findings 4 and 5 that have previously been discussed. My expectation was that each element - tasks, knowledge concepts, and skills - would each reach a minimum of 20% of the total of the element flagged by two or more participants. Since that minimum was not reached for any element, it is difficult to define a position or recommendation. My sense of the panel over 3 days, despite undocumented differences and the fact that several had graduate degrees in education, was they would exceed the 20% threshold at least for skills and knowledge concepts. The seven who participated did not meet this 20% threshold. I came away with no clear recommendation since the participants from Panel 1 did not have a consistent position on which tasks, concepts, and skills required training for new workers or veteran workers.

Research Question 1b: Findings

Finding 7: Method of Analysis and Data

Panel 1 participants found the DACUM process to be a satisfactory, successful, and challenging process.

Method of Analysis

One of the ways used to monitor the panel's interest and assessment of the process was to administer a basic Level 1 satisfaction survey at the end of each day. The survey (Appendix D) was administered at the end of day 2 and 3 for Panel 1. It was not administered to the participants on day 1 since we got such a late start on day one with little of the profile generated.

The first six questions were close-ended questions, using a 5-point Likert disagree-agree scale, and open comment boxes for the remaining questions. These questions were based on this study's research questions, and derived from the end of sessions satisfaction questions used by DACUM facilitators trained at Eastern Kentucky University (EKU Facilitation Center*,* 2011*)*.

Based on the scores registered for each question by the participants, the means and medians were calculated, as shown in Table 11, with an overall mean calculated for the first six questions. The goal was to see if the overall mean would be between 4.25 and 5.00. If the overall mean was in that range, then I would feel comfortable advocating for future DACUMs for chaplains.

Additionally, I reviewed the comments from four of the open-ended questions asked of each respondent.

The key survey questions which address Research Question 1b were questions four through nine. The following data supports this finding.

As shown in Table 11, for the 14 surveys submitted, the overall mean score, for the six closed-ended questions, was 4.57.

Questions 4, 5, and 6 had the following mean scores. Question 4: I found the DACUM process to be a good way to develop a profile for a health care chaplain had a mean score of 4.43. Question 5: I found the DACUM process to be challenging had a mean score of 4.29. Question 6: I found the DACUM process to be a success had a mean score of 4.43.

Table 11

Mean Scores from Six End-Of-Day Survey Questions Completed by Panel 1 Participants on Day 2 and Day 3

Survey Question N = 14	M	Mdn	SD
Q1: I understand the purpose of the research study using the DACUM process.	4.86	5	0.36
Q2: I expect the profile that results from this study will positively influence the role of health care chaplain.	4.71	5	0.47
Q3: The occupational profile developed so far accurately reflects what I do day-to-day.	4.71	5	0.47
Q4: I found the DACUM process to be a good way to develop a profile for a health care chaplain.	4.43	4	0.51
Q5: I found the DACUM process to be challenging.	4.29	4	0.83
Q6: I found the DACUM process to be a success.	4.43	4.50	0.65
Overall Mean	4.57		

The following written quotes from the four open-ended end-of-day survey questions capture the consensus of the Panel 1 participants.

Question 7: The most satisfactory aspect of the DACUM process has been _____.

C11: The collaboration of folks who know well of what they speak

C12: Interacting with my peers. Experiencing our commonality among our differences

C6: The hope that this will be a curriculum that all CPE students learn from

C9: Interaction of the participants

C9: Collaboration was an active key

Question 8: The most successful aspect of the DACUM process has been _____.

C10: As a chaplain, I had an opportunity to review the role of chaplaincy and other matters

C11: The process of mining the collective wisdom of the group

C12: The structural approach to our reflection and developing the profile

C6: Opportunity to think and process the task of a chaplain

C8: Articulating what chaplains do

Question 9: The most challenging aspect of the DACUM process has been _____.

C11: Maintaining focus

C11: Getting here on time, continuing to stay engaged in the process and maintaining necessary focus

C12: Sitting all day. I am usually out and about and on my feet.

C6: It's long. Too much sitting

C8: Putting the tasks into words everyone could agree with

C9: Struggling with the accurate meaning/words for the process

Q10: What are your thoughts, positive, negative, or neutral about the profile of the health care chaplain developed?

C10: Chaplains provide hope and healing to those who need spiritual and emotional support

C11: I hope this will fill in some of the major gaps so CPE will be a more practical and realistic experience

C12: I am excited about the possibilities it opens. With C9, I feel it describes the what--but the WHO is equally important. I am curious to see how this gets translated to CPE training

C6: Incomplete without personality traits

C8: We are consistent in what we do with patient visits, but not so much beyond that

C9: It has been a positive presented profile--enabling meaning to what I do and encouraging naming the process/task. It was a stimulating, inclusive study.

Finding 7: Interpretation

Based on the overall mean score of 4.57 for survey questions one through six and the comments submitted for questions seven through nine indicate that the Panel 1 participants came away with a sense of satisfaction and success using the DACUM methodology. The most satisfying aspect of the process, based on the respondent

comments, was the interaction, collaboration, and participation with their peers. The most successful aspect of the process for Panel 1 was the group process, which caused them to articulate what chaplains do. The most challenging aspect of the process was the sedentary nature of the methodology, which challenged the participants who are generally on the go.

Research Question 1bi: Findings

Finding 8: Method of Analysis and Data

Race, gender, and experience did not influence the health care chaplains' perception of what was satisfactory, successful, or challenging.

Method of Analysis

The method of analysis used for Research Question 1bi was the same method used for Question 1b. The only difference was for this research question the focus of the analysis was who said what in the end-of-day survey on questions seven, eight, and nine. In addition, I reviewed my memos and transcripts to identify any themes that would aid the analysis. I also reviewed my member-checking notes, and notes I had made during the post-panel interviews.

The following data supports this finding.

The following written quotes from three open-ended, end-of-day, survey questions capture the consensus of the Panel 1 participants.

Question 7: The most satisfactory aspect of the DACUM process has been _____.

C11: The collaboration of folks who know well of what they speak

C12: Interacting with my peers. Experiencing our commonality among our differences

C6: The hope that this will be a curriculum that all CPE students learn from

C9: Interaction of the participants

C9: Collaboration was an active key

Question 8: The most successful aspect of the DACUM process has been _____.

C10: As a chaplain, I had an opportunity to review the role of chaplaincy and other matters

C11: The process of mining the collective wisdom of the group

C12: The structural approach to our reflection and developing the profile

C6: Opportunity to think and process the task of a chaplain

C8: Articulating what chaplains do

Question 9: The most challenging aspect of the DACUM process has been _____.

C11: Maintaining focus

C11: Getting here on time, continuing to stay engaged in the process and maintaining necessary focus

C12: Sitting all day. I am usually out and about and on my feet.

C6: It's long. too much sitting

C8: Putting the tasks into words everyone could agree with

C9: Struggling with the accurate meaning/words for the process

Finding 8: Interpretation

Based on the following comments, which have been validated with my memos and transcripts, race, gender, experience, and religious affiliation did not appear to influence the participant's perception of what was satisfactory, successful, or challenging regarding the DACUM process. This might not have been so with a larger panel or a panel made up of chaplains from different regions of the county.

Next, in Chapter 5, I will examine the data, findings, and interpretations from Panels 2 and 5, the validation panels.

Chapter V

DATA, FINDINGS, AND INTERPRETATIONS FOR RESEARCH QUESTION 2

Introduction

On day 4 of the DACUM process, I met with the second panel of chaplains to revise and edit the profile provided by Panel 1. The purpose of the second panel was to validate the data compiled by Panel 1 and make any changes that the Panel 2 chaplains reached consensus on. The profile that resulted was considered a validated profile and was distributed to the members of Panel 5, who were from different geographic regions, for their input.

Chaplains from Panel 2 contributed their input during the time they met with me along with follow-up emails and telephone calls, while the Panel 5 chaplains provided their input strictly through the exchange of emails. To report the findings from Panels 2 and 5 and address Research Question 2, the data, findings, and interpretations for Research Question 2 will be reported in this chapter. Table 12 shows a mapping of panels to the research question, a brief description of the panel, the primary modality used for data collection, and the chapter where the data, findings, and interpretations are presented. As I did in Chapter 4, I begin this chapter with a brief discussion of panel demographics.

Table 12

Panel Descriptions, Logistics, and Panel to Research Question (RQ) Mapping

Panel	RQ	Description	Modality	Chapter
1	1	Initial Panel	In-Person	4
2	2	Validation Panel	In-Person	5
3	3	CPE Supervisor	In-Person	6
4	4	Curriculum Development	Web Conf.	6
5	2	Geographically Diverse Validation	Email	5

The outline of the data results and findings for Research Question 2 will be:

- Panels 2 and 5 Demographics
- Restate Research Question 2
- Research Question 2-Profile artifacts
- Panel 2 and 5 Overview
- Research Question 2 –Findings
    - Finding 1.0
        - Method of analysis
        - Data Supporting finding
    - Finding 1.0 Interpretation
    - Finding 2.0
        - Method of analysis
        - Data Supporting finding
    - Finding 2.0 Interpretation

    - Etc…(This is only a sample because each research question may have more than two findings.)
- Research Question 2a-Findings etc.
- Research Question 2b-Findings etc.
- Research Question 2bi-Findings etc.

I now present descriptive statistics based on frequencies regarding key Panel 2 and 5 demographics as compiled from the Demographics survey (Appendix A).

Panels 2 and 5 Demographics

Several key demographic descriptors were reviewed from the Demographic Survey because of their relevance to the research questions. These include Gender, Ethnicity, Age, Years as a Chaplain, Religious Affiliation, Ordination Status, Certification Status, Workplace Location, and Title.

Of the six participants on Panel 2, as shown in Table 13, twice as many were females as males. One-half (50.0%) of the participants identified themselves as white or Caucasian, while the panel's average age was 48 years old. Five of six participants (83.3%) were ordained or had professed their faith per the Roman Catholic rites. The majority of the Panel 2 participants (83.3%) were certified by one of the national certifying organizations. As to religious affiliation, half of Panel 2 (50.0%) self-identified as a member in one of the Protestant organizations, while less than a fifth (16.7%) self-identified as Jewish, Roman Catholic, or Quaker respectively. All six of Panel 2 participants served in New York City area hospitals, though one chaplain worked in a Long Island hospital and a second in a hospital in Ridgewood, New Jersey both of

Table 13

Panel 2 and Panel 5 Demographics Summary

Characteristics	Panel 2 Participants (N = 6) N	Percent	Panel 5 Participants (N = 13) N	Percent	Totals (N = 19) Percent
Gender					
Male	2	33.3	5	38.5	36.8
Female	4	66.7	8	61.5	63.2
Ethnicity					
Asian	2	33.3	0	0.0	10.5
African American	1	16.7	1	7.7	10.5
White or Caucasian	3	50.0	12	92.3	78.9
Eastern European	0	0.0	0	0.0	0.0
Age Distribution					
25-34	2	33.3	0	0.0	10.5
35-44	2	33.3	0	0.0	10.5
45-54	0	0.0	6	46.2	31.6
55-64	2	33.3	6	46.2	42.1
65-74	0	0.0	1	7.7	5.3
75+	0	0.0	0	0.0	0.0
Years As A Chaplain					
No Response	0	0.0	1	7.7	5.3
2-5	2	33.3	2	15.4	21.1
6-10	3	50.0	1	7.7	21.1
11-15	1	16.7	1	7.7	10.5
16-20	0	0.0	2	15.4	10.5
20+	0	0.0	6	46.2	31.6
Ordination Status					
No Response	0	0.0	2	15.4	10.5
No	1	16.7	1	7.7	10.5
Professed	0	0.0	1	7.7	5.3
Yes	5	83.3	9	69.2	73.7
Certification Status					
No Response	0	0.0	1	7.7	5.3
No	1	16.7	2	15.4	15.8
Yes	5	83.3	10	76.9	78.9
Religious Affiliation					
Protestant	3	50.0	11	84.6	73.7
Jewish	1	16.7	1	7.7	10.5
Muslim	0	0.0	0	0.0	0.0
Roman Catholic	1	16.7	1	7.7	10.5
Quaker	1	16.7	0	0.0	5.3

which were considered suburban facilities. The remaining chaplains served sites in the five boroughs of New York City - Manhattan, Bronx, Brooklyn, Queens or Staten Island. Three of the participants had the title of Director, while one self-identified also a Supervisor of Chaplaincy Services. The remaining three participants self-identified as staff chaplain.

Of the 13 participants on Panel 5, as shown in Table 13, approximately twice as many were females as males. The majority (92.3%) of the participants identified themselves as white or Caucasian, while the panel's average age was 60 years old. Ten of 13 participants (76.9%) were ordained or had professed their faith per the Roman Catholic rites. The majority of the Panel 5 participants (76.9%) were certified by one of the national certifying organizations. As to religious affiliation, the majority of Panel 5 (84.6%) self-identified as a member in one of the Protestant organizations, while less than 10 percent (7.7%) self-identified as Jewish, or Roman Catholic respectively.

Participants who spanned most age ranges were certified and ordained and represented many of the mainstream religious organizations validated the profile.

In summary, after reviewing the demographics of gender, ethnicity, participant age, participant experience, religious affiliation, ordination, and certification status, I concluded that I had a reasonably balanced representation for validation. The profile was reviewed by a diverse, experienced, blend of health care chaplains and it was representative of their vision of the role. When comparing the first two panels and Panel 5 demographically there are two metrics that stand out. They are age and years in chaplaincy. Both Panel 1 and Panel 5 had a higher percentage of participants above the age of 45-54 while the majority of the chaplains on Panel 2 were in the range of 25-44.

The same holds true when years in chaplaincy was explored. On Panels 1 and 5 over half of the participants served over 16 years, while on Panel 2 the majority served less than 15 years as a chaplain. This variance in age and service may account for some of the findings that will be discussed later in this chapter.

Next, I review the second research question that provided the foundation for my study of health care chaplains.

Research Question 2 Review

In fulfilling this study's purposes, I will answer the following questions:

2. From the perspective of the validation DACUM panel of health care chaplains, what are the competencies, i.e., duties, tasks, knowledge, skills, identified for the role of health care chaplain?
    c. From the perspective of the validation DACUM panel of health care chaplains, what knowledge, skills, and tasks are identified as new worker training needs, and veteran worker training needs?
    d. From the perspective of the validation DACUM panel of health care chaplains, what are the most satisfactory, successful, and challenging aspects of the DACUM process?
        i. On the validation panel, how does race, gender, experience, and religious affiliation influence the health care chaplains' perception of what is satisfactory, successful and challenging?

Now that I have restated Research Question 2 and its associated questions, I will next present the artifacts that were produced by the second panel.

Research Question 2: Profile Artifacts

The profile of a health care chaplain that was validated by Panel 2 and reviewed by Panel 5 using the DACUM methodology consists of several key artifacts. These provided the framework for my findings in response to Research Question 2 and its sub-questions. The artifacts that Panel 2 helped to develop at the end of their half-day session were:

- Artifact 1: A revised job description
- Artifact 2: A revised and validated, graphical, prioritized storyboard with duties and tasks
- Artifact 3: A revised and validated rank ordering of duties per importance based on the amount of time spent performing during a typical week
- Artifact 4: A revised and validated, prioritized, list of concepts chaplains need to know to be successful
- Artifact 5: A revised and validated, prioritized, list of skills chaplains need to be successful
- Artifact 6: A revised and validated, list of traits and tools chaplains need to be successful

All of these were shared with Panel 5 by email for validation based on each participants' geographic location.

Artifact 1: A Revised Job Description

The revised and validated job description developed by Panel 2 was crafted based on their response to the initial job description that Panel 1 delivered and was discussed in Chapter 4. The revised and validated job description developed by Panel 2 was

assembled based on their responses to the following four propositions: Who, What, How, and Why. To be consistent with chapter 4, I present the final job description revised and validated by Panel 2:

> Professional health care chaplains help create a sacred space for people of any or no faiths and cultural beliefs in stressful, life-changing or transitional moments to find meaning, hope, connection, and comfort by enabling them to identify and draw upon their own sources of inner strength.

Artifact 2: A Revised and Validated, Graphical Storyboard

The initial storyboard that was developed consisted of nine duties and 60 tasks. The revised and validated storyboard that was modified by Panel 2 consisted of nine duties and 63 tasks. Four of the duties were modified by Panel 2 as were 55.6% of the tasks that were on the initial storyboard. The left side of the storyboard displaying duties and the first five associated tasks is shown in Figure J1 as shown in Appendix J. The right side of the storyboard with the remaining tasks for each duty band is shown in Figure J2 as shown in Appendix J.

Artifact 3: A Rank Ordering of Duties Based on Two Metrics

Two rank ordering exercises were conducted at the completion of the validated storyboard. In the first exercise, the panel ranked the duties in importance from most to least. In the second exercise, the panel ranked the duties per the amount of time spent on each. The results of both exercises are shown in Table 14.

Table 14

Panel 2's Rank Ordering of Duties Based on Importance and Time Spent

Duty Band Identifier	Ranking based on Importance	Percent of time spent during work week	Duty Band Name
A	1	17.6%	Conduct Chaplaincy Encounters
B	8	6.4%	Provide Education
C	9	6.6%	Provide Institutional Leadership
D	6	8.8%	Promote Chaplaincy Care
E	4	34.4%	Administration
F	7	6.0%	Facilitate Connections
G	5	5.2%	Professional Dev. And Self-Care
H	3	10.6%	Team Participation
I	2	4.4%	Triage Visits

Artifact 4: A Revised List of Concepts Chaplains Need to Know

Thirty-three items, shown in Table 15, were validated by Panel 2 as key concepts that health care chaplains must know to be successful. The highest number of labels affixed to a knowledge concept was three for new worker training needs and veteran worker training needs. Those concepts that two chaplains labeled were incorporated into a list of concepts that new and veteran workers need training in and could be used in the prioritization of curriculum objectives. In Table 15, all knowledge concepts are represented with the number of labels applied by Panel 2 participants.

Table 15

Concepts Identified by Panel 2 that Health Care Chaplains Need to Know and Those Identified as Needed for New Workers and Veteran Workers

NW Training Needed	VW Training Needed	Knowledge Concepts
3		Hospital chain of command
		Knowledge of differences
		General understanding of other health care roles
		Knowledge of other team member's roles
		Knowledge of other cultural traditions
	1	Bereavement theory
1		Medical terms
1	1	Knowledge of self
		Deep knowledge of own faith traditions
		Hospital policies and procedures
1		Boundaries
		Ethics
		HIPPA
		Theological grounding
		Stages of human development
1		Knowledge of hospital/institutional culture
		Substance abuse
		What your job is NOT
		Working knowledge of other faith traditions-protestant traditions
1		Knowledge of Gods messengers (Knowledge of sacred texts)
		Community organizations
	1	Who can get things done
		Stages of faith development
1		Basic computer applications
		Triangulation
		Knowledge of psychological systems
		Transference/counter transference
		End of life care/advanced directives
		Disaster training
		Palliative care principles
		Knowledge of religious practices
1		Religious protocols and practices

Artifact 5: A Revised List of Skills Chaplains Need to Have

Twenty-seven items, shown in Table 16, were identified by Panel 2 as key skills that health care chaplains must have to be successful. Eighteen of the skills were validated from the list provided by Panel 1 with nine additional skills added by Panel 2. The highest number of labels affixed to a skill was four for new worker training needs and two for veteran worker training needs. Those skills that two chaplains labeled were incorporated into a list of skills that new and veteran workers need training in and could be used in the prioritization of curriculum objectives. In Table 16 all skills are represented with the number of labels applied by Panel 2 participants.

Table 16

Skills Identified by Panel 2 that Health Care Chaplains Need to Have and Those Identified as Needed for New Workers and Veteran Workers

NW Training Needed	VW Training Needed	Skills
1		Active listening
		How to communicate in a crisis situation
1		Communication skills
		Develop relationships
	1	Think quickly on your feet
	1	Leadership
		Know when to refer
		Politicking inside institution (diplomacy)
4	2	Self-care
		Non-sectarian prayer
1		Work-life balance
	1	Computer skills
1	1	Conflict management
		Mediation
1		Articulation of faith traditions
		Leading ecumenical worship service
		Managing crisis situations to diffuse

Table 16 Continued:

NW Training Needed	VW Training Needed	Skills
1	1	Transferable skills from previous jobs
		Public Speaking
		Defining Boundaries
		Time Management
	1	Organization
1	1	Team Work
	1	Research Literacy
	1	Multitasking
		Presentation
	1	Teaching

Artifact 6: A Revised List of Traits and Tools Chaplains Need to Have

Panel 2 participants identified 17 traits in addition to the 23 traits identified by Panel 1. Panel 2 also expanded the list of tools from two tools to 24 as key to being a successful health care chaplain. In the language of DACUM, traits and tools are considered enablers and are not part of the prioritization exercises. The traits identified by Panel 1 and validated by Panel 2 that health care chaplains need to be successful were of two categories: those that were generic traits, and those that were religious traits. The generic or behavioral traits identified by Panel 1 were intuitive, resilient, patient, joyful, sense of humor, compromise, flexible, assertive, self-confident, persistent, has a strong stomach, reliable, has a positive outlook, and humorous. The generic or behavioral traits identified by Panel 2 were vulnerable, mindful, self-controlled, humble, self-motivating, calm, open-minded, introspective, nonjudgmental, kind, engaging, approachable, curious, and works well independently. The religious traits that were identified by Panel 1 were pastoral identity/authority, faithful, hopeful, personal spiritual life, speak the truth,

grounded in own theology, creates a safe space, enables others to experience hope and meaning, and understands relationships and how they impact the patient. The additional religious traits that were identified by Panel 2 were empathetic and compassionate. The tools identified by Panel 1 consisted of only two items- a Rolodex and a Referral List. The additional tools identified and validated by Panel 2 were: telephone, computer, Internet, Outlook, patient chart, religious articles, prayer card, calling card, business card, tablet, hand sanitizer, Xerox, printer, comfortable shoes, pager, smart phone, Instant Messenger, Google, ID badge, watch, Skype, and professional attire.

Now that I have reviewed the artifacts that Panel 2 contributed to, I now present a brief overview of Panel 2 and my findings.

Panel 2 Overview

Panel 2 was scheduled to begin at 9:30 AM on day 4 but did not begin until almost 10:30 AM because of travel delays that all participants experienced. When we got underway, I had six highly intelligent, articulate, caring and vocal participants in the room who completed the validation in under 5 hours. The panel was made up of three staff chaplains and three chaplains who were doubling as directors. Despite the relatively small number of participants and the abbreviated schedule, the panel had six interested and engaged participants throughout the proceedings. Once we started, and I explained the purpose of this study, everyone seemed ready to contribute. I came away from Panel 2 knowing they had produced a profile for going forward.

Now I present a list of my findings for Research Question 2, and it's three sub-questions. After the list of findings is presented, each finding with an interpretation will be presented.

Research Question 2: Findings

The following are my findings that pertain to Research Question 2. The reason why each of these findings became notable will be explained later in this chapter.

1. Panel 1's job description was rewritten giving the role a different focus by Panel 2.
2. The words Pastoral and Prayer were removed from the storyboard developed by Panel 1, and replaced by Chaplaincy and Chaplaincy Presence in the storyboard validated by Panel 2.
3. With a few exceptions, the participants from Panel 5 said the profile developed in NYC by Panel 1 and Panel 2 transferred to the five represented geographic regions.

Research Question 2a: Findings

4. Only four tasks where new workers needed training or where veteran workers need training were flagged by at least two Panel 2 participants.

Research Question 2b: Findings

5. Panel 2 participants found the DACUM process to be a satisfactory, successful, and challenging process.

Research Question 2bi: Findings

6. Race, gender, and experience did not influence the health care chaplains' perception of what was satisfactory, successful, or challenging.

For the remainder of this chapter, I examine each of these findings, one-by-one, the methods used for data analysis, the data supporting the finding, and my interpretation

of the finding and its data. I now begin by looking at the findings associated with Research Question 2 starting with Finding 1.

Finding 1: Method of Analysis and Data

Panel 1's job description was rewritten giving the role a different focus by Panel 2.

Method of Analysis

The analysis was conducted in three steps. First, I reviewed the two job descriptions to assess the differences and similarities. Next, I examined the two job descriptions in Table 17, comparing the components of each using the four questions that were leveraged for their creation, namely who, what, how, and why. Finally, I reviewed the relative portion of the interaction that transpired during Panel 2 that resulted in the validated job description.

The following table, job descriptions, and interaction provide the data that supports this finding.

Table 17

A Comparison of Relative Sections from Panel 1 and Panel 2's Job Descriptions

Job Description Section	Panel 1 Data	Panel 2 Data
Who	Professional health care chaplains, grounded in faith,	Professional health care chaplains
What	enable people to access their spiritual-emotional resources	help create a sacred space for people of any or no faiths and cultural beliefs in stressful, life-changing or transitional moments

Table 17 Continued:

Job Description Section	Panel 1 Data	Panel 2 Data
How	Chaplains achieve this by doing a spiritual assessment, developing and implementing a care plan, measuring outcomes and providing documentation.	by enabling them to identify and draw upon their own sources of inner strength
Why	in order to provide hope, comfort, and healing.	to find meaning, hope, connection, and comfort

For comparison, I present the final job descriptions from Panel 2 and Panel 1.

Final Revised and Validated Job Description Developed by Panel 2:

Professional health care chaplains help create a sacred space for people of any or no faiths and cultural beliefs in stressful, life-changing or transitional moments to find meaning, hope, connection, and comfort by enabling them to identify and draw upon their own sources of inner strength.

Initial Job Description Developed by Panel 1:

Professional health care chaplains, grounded in faith, enable people to access their spiritual-emotional resources in order to provide hope, comfort, and healing. Chaplains achieve this by doing a spiritual assessment, developing and implementing a care plan, measuring outcomes and providing documentation.

Panel 2 began by reviewing Panel 1's job description. After 20 minutes of doing a systematic review, Chaplain V4 offered his email signature which follows. The panelists unanimously agreed that it needed to be the foundation for the job description. Chaplain V4 emailed his signature to me, and it was entered on a flip chart sheet for later review.

What follows are the email signature and the ensuing interaction and edits that led to the final, validated, job description delivered by Panel 2, and a comparison of Panel 1 and 2's job description in Table 17.

V4 email signature:

Chaplains are women and men who help create a sacred space for people of all faiths and cultural beliefs in stressful, life-changing or transitional moments to find meaning, hope, connection, and comfort by enabling them to identify and draw upon their own sources of inner strength.

V7: I object to the use of the word men and women for chaplains why not just call them professional health care chaplains as opposed to the men and women who are chaplains?

V1: It just means all chaplains.

V4: We could just say professional health care chaplains.

V6: I like that.

V6: As opposed to saying all faiths what about saying any or no faith to be more inclusive? You have a right to say you have no faith so any or no faith or faiths would be appropriate.

V2: Agreed.

V6: This is very empowering!

V7: Is this a good elevator speech a good elevator pitch?

V4: If you have their email address <laugh>

Facilitator: Should we include the four outcome oriented actions from the first job description from the panel one job description?

V7: This is good. No need to add those extra four.

V5: Agreed.

V2: The Presbyterian in me thought you were going to ask if we should replace the substitute motion and let it become the main motion?

<Laugh>

V7: The Presbyterian in me thought you would ask us to take a vote.

<More laughter>

V2: Can I take a picture of this?

Facilitator: Sure, go ahead.

V4: I will email it to you.

V1: The Quaker in me wanted to say let's have a moment of silence.

V6: I love it.

Facilitator: So, we are good with the following?

Professional health care chaplains help create a sacred space for people of any or no faiths and cultural beliefs in stressful, life-changing or transitional moments to find meaning, hope, connection, and comfort by enabling them to identify and draw upon their own sources of inner strength.

All six Panel 2 chaplains said Yes.

Finding 1: Interpretation

On the surface, the two job descriptions from Panel 1 and Panel 2 have some similarities and some differences. The main similarities come in the two panels responses to the who question and the why question. For the question who, both said "professional health care chaplains," while for the question why, both said "in order to

provide hope and comfort." Despite the two panels minor differences in their responses to who and why, their focus was the same. The main differences come when looking at the responses that each panel made to the what question and the how question. When asked what a chaplain does, the Panel 1 chaplains said "enable people to access their spiritual-emotional resources." Panel 2 chaplains had a different focus when asked what a chaplain does. The Panel 2 chaplains said, "help create a sacred space for people of any or no faiths and cultural beliefs in stressful, life-changing or transitional moments." When asked the question how a chaplain does the job, Panel 1 chaplains said, "chaplains achieve this by doing a spiritual assessment, developing and implementing a care plan, measuring outcomes, and providing documentation." When asked the same question, Panel 2 participants said, "by enabling them to identify and draw upon their own sources of inner strength."

The responses to the what and how questions by the Panel 1 and Panel 2 chaplains demonstrate a different focus or vision for the role of the health care chaplain. Panel 1's response to the what question is similar in tone to Panel 2's response to the how question. If Panel 2 had been open to including Panel 1's how statement, it would be easy to conclude the job description was truly representative of both panels. Since Panel 2 was not open to including the how statement from Panel 1 the focus of the job descriptions seems different. Despite the similarities, the key differences lie in what a chaplain does and how a chaplain does it. The focus of some chaplains seems to be on creating a sacred space for people while the focus for others seems to be on enabling people to access their spiritual and emotional resources.

Next, I present the second finding from Research Question 2.

Finding 2: Method of Analysis and Data

The words Pastoral and Prayer were removed from the storyboard developed by Panel 1, and replaced by Chaplaincy and Chaplaincy Presence in the storyboard validated by Panel 2.

Method of Analysis

The analysis was conducted in four steps. First, I reviewed the storyboard for the frequency of occurrence of each sacred term, and derivatives of the terms. Second, I noted the tasks where sacred terms were used. Third, I noted the duty bands where the sacred terms were used. Fourth, I reviewed excerpts from an interaction involving all participants. Each of these steps were done as a result of the discussion that occurred during Panel 1 as discussed in the previous chapter.

The following frequency data and three interactions provide the data that supports this finding.

The terms *spiritual, pastoral, religious,* and *prayer* occurred six times on the validated storyboard, zero times in duty band labels, and in five unique tasks. Three tasks were edits from the Panel 1 storyboard, and two tasks were carried over verbatim from the Panel 1 storyboard. Eight percent of the tasks used one of the four sacred terms. The words clergy and chaplain were not considered sacred for the finding since they are terms that define an occupational role that might be found on a nurses' or social worker's storyboard.

The word *spiritual* occurred in four tasks: A2: Conduct spiritual assessments; B3: Provide ongoing spiritual/religious staff education; C2: Serve as a resource and point

person for moral, ethical, and spiritual issues; and E2: Ensure timely and appropriate delivery of spiritual care.

The word *pastoral* was removed from the four tasks where it had been used in the Panel 1 storyboard. This resulted in zero tasks using the term pastoral in the validated storyboard delivered by Panel 2. The word *pastoral* which also occurred in two of the duty identifiers in the Panel 1 storyboard was also edited out in the validated storyboard. This resulted in a validated storyboard with no occurrences of the word *pastoral*.

The word *religious* occurs in two tasks in the validated storyboard. It should be noted that one task also contains the word *spiritual:* B3: Provide ongoing spiritual/religious staff education. The second task was F3: Facilitate relationships with religious and community groups.

The word *prayer* occurs in one task in the Panel 1 storyboard. C5: Initiate and/or lead prayer. In the validated storyboard, the word *prayer* does not occur as a duty or a task of a health care chaplain.

The following interaction which occurred at an hour and a half into the morning session provides some of the background for the edits that were made. It begins with the edits requested for the title given to Duty A.

V2: I don't want to make a big to do about this, but the word pastoral is not used very much by students or chaplains these days!

V4: We tend to use spiritual care. The best practice today is to avoid the use of the word visit and to use something like consult or encounter.

Facilitator: So give me the language.

V6: One is definitely broader than the other. I prefer encounters.

Facilitator: So are you saying that we should change Duty A from Conduct Pastoral Visits to Conduct Chaplaincy Encounters. Everyone agree?

<Everyone's head nodded in the affirmative!>

Facilitator: Let's get it on the board!

V5: I'm wondering if this is just a regional issue? For example, down south chaplaincy encounter and a chaplaincy consult might be misunderstood as not being a visit.

V1: New Jersey where I work with primarily Protestant Christians where pastoral would be something that they would be very comfortable with, while the word chaplaincy encounters this would confuse them.

V6: So, is this what we do? Is what we aspire to? Is it what we do? And is chaplaincy encounters correct?

V4: It is what we aspire to.

Facilitator: (Holding up the card) Is this a general area of competence?

Everyone: Yes, it is.

V2: When we get to the next box, A1: Establish Pastoral Connections, I'm not sure if you want us to sign off on this or if you want us to redo and rework it.

Facilitator: Validate it, and make the changes you deem necessary.

V2: Okay then I would like to see us come up with language for Establish Pastoral Connections.

Facilitator: So, give me some language.

V7: Establish Chaplain Connection.

V2: I would take it another step further and say Establish Chaplain/Patient/Family Connection.

V6: I would say Establish Chaplain/Patient/Family/ Staff connection.

V2: That works.

V1 and V5: Perfect.

Facilitator: (holding up the card) Okay, is this what you do?

Everyone: yes, it is.

V2: While we are doing these, can we also change the duty on Promote Pastoral Care to Promote Chaplaincy Care and change task C1 Conceptualize vision for pastoral care that supports and enhances the institutional mission to Conceptualize vision for chaplaincy care that supports and enhances the institution

Facilitator thoughts anyone? <Silence> Everyone good then?

Everyone: good, good!

V2: I think the institutional prayer is one thing that we could discuss but the individual prayer would come under A4: Conduct Chaplaincy Interventions

V6: At institutional events, we become the "pray-ers," the ones who offer the invocation, etc. So, we should address that aspect of the role as well as the aspect of the individual prayer.

V2: I agree I don't think we can lose either aspect of the role but I do think that the individual prayer comes under the Conduct Chaplaincy Interventions task.

Facilitator: So, what's our language?

V1: Change C5 to Provide chaplaincy presence at institutional events

V2: I agree.

V6: I like it.

V7: It makes sense.

V6: And just to be clear the patient initiates prayer we don't.

V5: Agreed!

V4: Perfect!

Finding 2: Interpretation

The main thing that the data reveals is that as health care chaplains there is both a need and a trend to avoid the use of traditional sacred language when reflecting on, and describing what they do daily. Though this may be in opposition to what patients believe the role is about, Panel 2 affirmed quite plainly that even though their training was through the CPE (Clinical Pastoral Education) process, they did not see what they did as pastoral. Reflecting on the language choices arrived at by Panel 2, based on the limited use of traditional sacred terms, the role of health care chaplain seems to have evolved into a secular role within health care.

Finding 3: Method of Analysis and Data

With a few exceptions, the participants from Panel 5 said the profile developed in NYC by Panel 1 and Panel 2 transferred to the five represented geographic regions.

Method of Analysis

The data from Panel 5 were gathered by the exchange of email. Thirteen chaplains responded by completing the demographic survey found in Appendix C, but only 11 chaplains responded to the four questions asked in the email requesting participation. The 11 chaplains represented the five regions of the United States, namely the Northeast, the Southeast, the Midwest, the West, and the Southwest. Chaplains G1 and G2

represented the Southeast. Chaplains G3 and G4 represented the Northeast. Chaplains G5, G6, and G7 represented the Midwest. Chaplains G8 and G9 represented the West. Chaplains G10 and G11 represented the Southwest. I reviewed the comments from the four open-ended questions asked of each respondent by email, compiling them together according to question. Then I analyzed each question for common themes.

For review, the four open-ended questions asked of the respondents were:

1. Does this profile accurately reflect what you do in your role as a health care chaplain?
2. Does the profile developed in NY transfer to your geographic region?
3. If it does, please identify elements that are an accurate reflection.
4. If it does not, please identify those elements that are not an accurate representation or gaps that you have identified.

The following responses by question provide the data that supports this finding.

Question 1: Does this profile accurately reflect what you do in your role as a health care chaplain?

G1: Yes, it does.

G2: Yes, some items that seem missing or less emphasized that we do frequently are staff support, not only crisis intervention and debriefing but classes on compassion fatigue and empathy, providing one on one and group teammate support, etc.

We also are increasing our involvement with education and support for 'Patient Experience' domains. Spiritual care is now under the Patient Experience division

of our hospital system and a charged with several of the system goals related to Patient Experience.

We do a significant number of sacramental/ritual responses such as blessing/baptism/dedication for fetal demise.

We are also do all the advance directive education and assist with completing documents. At our hospital, this probably accounts for 30 – 40% of chaplain consults.

G3: We are a 600-bed, Level I trauma center, a regional teaching hospital in Maine's largest city of 65,000. We are terribly understaffed as a Spiritual Care Department - 3 BCC's, one of whom is a CPE supervisor and Department Director with minimal clinical time. Another is one of our service line chaplains, covering our Women and Children's Service line of over 100 patients, as well as covering on call and involved in research.

We have four CPE residents (2.5 days per week), two Catholic priests for the 25% Catholic patients and a part-time Roman Catholic sister and Jewish (lay) chaplain –the last four are gifts from their community sponsoring bodies.

So, we are stretched very thin!

The profile is fairly accurate for my role and our geographic region and hospital context. The nine duties are accurate, although it was not clear why Triage Visits is listed separately from Conducting Chaplaincy Encounters.

G4: Yes. I looked at all of the items and felt it is a very accurate description of the role. In my role as CPE Supervisor I also do lots and lots of administrative tasks: respond to inquiries about the CPE program, market the program, develop

curriculum activities (for example, sim lab component), etc. However, the chaplain part of my job is extremely well articulated.

G5: Yes

G6: 67% (43 of the 67 items) of the duties/tasks in the DACUM Profile align with my role as a health care chaplain. I believe the profile, in general, accurately reflects the role of health care chaplains.

G7: Yes, quite well. Perhaps these are captured already, but I would add:

"Skills" - "Demonstrates critical thinking and thought leadership." "Executes for results." "Conducts Needs Assessments." "Creates needs-based education and enrichment programs for staff."

"Knowledge" – "Organizational/Culture Change and Transformation Theory." "Mediation and Conflict Resolution."

"Tools" – Accessible library.

"Traits" – Adaptability. Risk-taking.

G8: Yes and no. I am a full-time designated palliative care chaplain in a West Coast faith-based community hospital. So, my role is weighted heavily toward the "team participation," "provide education," "administration" and "professional development/self-care" activities. Since I operate as a full-time interdisciplinary team member, many of the solo tasks that used to be critical or frequent tasks when I was a staff chaplain (conduct referred visits, conduct services, identify and maintain relationships with 'chaplaincy champions') don't apply to my current context.

G9: Yes. Terrific profile. Thank you for including me in your panel. I am inspired and fascinated by this impressive body of work.

G10: Yes, when I was in clinical practice and in the areas where I was assigned. However, it was not the profile expected within my department, which did not place priority on comprehensive spiritual assessment or interdisciplinary work, such as participating in rounds, care conferences, etc. Self-care was not encouraged within the department.

G11:Yes

Question 2: Does the profile developed in NY transfer to your geographic region?

G1: Yes, it does.

G2: For the most part.

G3: For the most part.

G4: Yes

G5: Yes

G6: Yes, I believe it does transfer with to my region with slight modifications based on my health care system focus and geographic region. One major gap is the aligning of patient care with their values/documenting patient health care wishes through the completion of health care power of attorney documentation.

G7: Yes. What will vary is the level of sophistication and expectations of the institutional culture, and whether or not the institution is urban, suburban, etc.

G8: Yes, the role and tasks accurately reflect the activities of our staff chaplains.

G9: Yes, it generally transfers to our geographical area, however not entirely. Allow me to offer some thoughts that may expand the context and scope. If some of these are new ideas for you, and you use them, kindly acknowledge me.

My perspective: I am a Jewish chaplain who is a physician (former emergency medicine physician). I founded The Jewish Chaplaincy at Stanford Medicine, a community funded program organized by Stanford Health Care that serves Stanford Health Care (adults), Stanford Children's Health (children and mothers), the School of Medicine and the local Jewish community. At the Medical Center I provide:

- Spiritual care to patients, families, and staff.
- Jewish spiritual care programs that are open to the entire medical center and surrounding communities.
- Educational activities for medical students, physicians, chaplains, spiritual care volunteers, area clergy and congregations.
- Some research.

G10: Not overall; my geographic region does not operate under current SOPs for chaplains.

G11: Yes

Question 3: If it does, please identify elements that are an accurate reflection.

G1: Frankly Warren, I believe you have accurately exquisitely described my role as a director of pastoral care in a large public hospital that is also an academic medical center and specialty hospital. Well done! Specifically, I do the following activities in my role as a chaplain and director of our pastoral care:

Row A—Conduct Chaplaincy Encounters,

Row B—provide education in all areas listed in the profile,

Row C—provide institutional leadership except for leading and facilitating groups,

Row D—promote chaplaincy care in all areas listed,

Row E—administration including everything listed,

Row F—facilitate connections in all areas listed,

Row G—provide professional development and self-care. I want to make more contributions to the field through research, teaching, and publication in the next 2-5 years,

Row H—team participation, all of the areas listed, and

Row I—triage visits, all the areas listed.

I was not prepared to do the following tasks in my CPE program many years ago: Measure Outcomes, Create and negotiate department budget, Contribute to the field through research, teaching, and publication.

G2: No Response

G3: While they are very important, things like "Identify opportunities for system-wide improvement for healing and justice," "Stay abreast of internal and external trends impacting the role of chaplains," and "Market chaplaincy through multiple media" are not high on my job description, nor is their time to implement. The Administration tasks like budgeting are not part of the line chaplain job, but I do coordinate/recruit/training local clergy and volunteers.

G4: Promote collaboration among patient staff and family;

Help patients/family navigate the health care system and beyond;

Model teamwork within the department.

G5: All nine duties identified reflect the duties of my work.

G6: Please see DACUM Profile (shown in Figures J1 and J2).

Row A: All tasks

Row B: All but B1, B3, and B7

Row C: All but C2, C4, and C6

Row D: All but D4

Row E: All but E6 and E7

Row F: All but F3

Row G: All but G4, G8, and G9

Row H: All but H4 and H6

Row I: All tasks

G7: There is nothing in the Profile that is NOT an accurate reflection of my ministry.

G8: I especially resonate with the "Tasks not prepared for by CPE" such as measuring outcomes, budget, participation in QI, and developing policies and procedures. I have not seen any CPE program preparing interns/residents for these activities. In general, I have seen that chaplains find it difficult to learn how to "serve on specialized team" including palliative care teams.

G9: Much of my work is encompassed in what you have aptly described in Duty A-I. Also, my work extends to developing spiritual care in the community, and in the practice and organization of medicine and health care.

G10: Conduct assessments and document; conduct referral visits.

G11: Establishing connections with patients, families, and health care professionals; conducting spiritual assessments; providing chaplaincy interventions; developing chaplaincy care plans; providing chaplaincy education; providing institutional leadership; promoting chaplaincy care; administration; professional development; teamwork; triaging needs.

Question 4: If it does not, please identify those elements that are not an accurate representation or gaps that you have identified.

G1: We are also expanding into outpatient chaplaincy and community partnerships as a pastoral care department.

G2: Some items that seem missing or less emphasized that we do frequently are staff support, not only crisis intervention and debriefing, but classes on compassion fatigue and empathy, providing one on one and group teammate support, etc.

We also are increasing our involvement with education and support for 'Patient Experience' domains. Spiritual care is now under the Patient Experience division of our hospital system and a charged with several of the system goals related to Patient Experience.

We do a significant number of sacramental/ritual responses such as blessing/baptism/dedication for fetal demise.

We are also do all the advance directive education and assist with completing documents. At our hospital, this probably accounts for 30 - 40% of chaplain consults. An activity we do more often, perhaps related to our geographic

location, is interact with local clergy who use our hospitality room and provide education and hospitality for local clergy.

G3: Pieces that are no longer part of my weekly tasks are "Providing chaplaincy presence at institutional events" and "Conducting services" (although I am occasionally asked to do a memorial or wedding). An area of important growth is in Measuring Outcomes.

I am astounded that your panels listed the following under "Tasks not prepared for by CPE": Conduct Spiritual Assessments, Document Visits, Develop Care Plan, and Interact with interdisciplinary team(s). If this is true, CPE truly needs revamping. They are core to the work of chaplains, perhaps not so easy to teach in a beginning unit, but critical to Spiritual Care.

G4: No response.

G5: While we have been very involved in the development of the documentation of our care plan in the EMR, we are not involved with social media. We are not a CPE center, so our teaching of students are of other professions, and the community education we offer is very limited. The one gap that I see in the profile is the spiritual care of staff. This is a huge time consumer in the work that we do in our setting. While a small nod is given to this in the elements of the profile, it is not highlighted in the way that it should be to reflect the effort we put into staff care in our setting.

G6: See my response to Question 3.

G7: The only elements of the profile I am not currently involved in are: "conducting annual performance reviews," and "create and negotiate department

budget," though I have in the past and currently contribute thought leadership to both. I am not sure what "Identify opportunities for system-wide improvement for healing and justice" means, so I would say that is also not an accurate representation.

G8: No response.

G9: In addition to your categories A-I, there are other activities I do that have to do with leadership that may be outside the scope of "Provide Institutional Leadership."

1) Founding and directing The Jewish Chaplaincy at Stanford Medicine as a different model of spiritual care involved entrepreneurial and intrapreneurial skills. These include design, planning, implementation, community building, organizational/advisory board development, program development, staffing, fundraising (foundations - proposal, reports, renewal; individual and families – identifying, making the ask, stewardship, etc.), advertising, marketing, etc.

2) At the Stanford School of Medicine where I became a Clinical Professor (adjunct faculty), we instituted a curriculum on spirituality and meaning in medicine for medical students over the past 14 years. It portrays spiritual care in a Bio-PsychoSocial-Spiritual context of medicine and health care. Conceiving and implementing a new curriculum involved same entrepreneurial spirit and skills. Once conceived, what I do seems to be captured in your well-described categories: B: Provide Education and C: Provide Institutional Leadership. However, the new conception could be seen as having to do with leadership in the spiritual care field itself (see next section). This dimension of education in

developing the field would extend beyond the institution, to impact health care organization and conferences, e.g., Joint Commission, AMA, health care organizations, WHO, etc.

There are other activities that have to do with leadership that do appear to me outside the scope of "Provide Institutional Leadership" - leadership activities that contribute to the development of the profession and practice of Spiritual Care itself.

1) I participate in NAJC (Neshama Association for Jewish Chaplains, formerly, National Association of Jewish Chaplains) on the Executive Board as Acting President/Vice President.

2) I was a member of the NAJC delegation to Israel that helped establish Israeli standards to develop spiritual profession there.

3) I am a founding member of the Global Network for Spirituality and Health and serve on its Leadership Council and Steering Committee.

"Provide Education" and "Provide Institutional Leadership" are their own domains, yet they are also key aspects of providing leadership in developing the field of spiritual care. I think this holds true for "Professional Development and Self Care." There is a stage of professional development where one becomes a resource for others. As this develops, one may become involved in developing the field of Spiritual Care itself. For me, in recent years, I've become a resource to others who are contemplating careers in spiritual care, as well as to those who are providing, teaching and organizing Spiritual Care. The people I have mentored/advised have included: chaplains (certified and board certified), area

clergy, medical students, physicians (those who want to include it in their practice as well as those contemplating becoming a chaplain or taking CPE), nurses, and spiritual care volunteers, from my area and around the country. (I would like to note, that while I am a resource to others in some areas, I am developing competency at others. I find this always humbling and curious.)

In conclusion, I suggest another domain of activity that is concerned to define, design, and develop the field of spiritual care itself (including the profession): Leadership of the Field. At this level, one is engaged in becoming/being a "Master" or "Master Chaplain" who participates in the invention/reinvention of the field of spiritual care itself. (Not all people who are participating at this level are chaplains, e.g., Puchalski, Koenig, Ferrel…)

In making the distinction "master," I am borrowing from the "Stages of Learning" articulated by philosopher/management consultant Fernando Flores et al. that I studied with in the 3-year Ontological Design Course and with whom I apprenticed.

- Blind (doesn't know that doesn't know).
- Ignorant (knows that doesn't know, begins to understand what the domain of actions are, not yet committed to acting).
- Beginner (knows that they don't know, committed to learning, finds a teacher/guide, gives trust to that teacher/guide, follows instructions, and gets started).

o Advanced Beginner (begins to act in the domain under the supervision of the teacher/guide, encounters breakdowns, makes errors, mistakes, cannot yet avoid them).

o Competent (acts on own, according to the standards of the community, anticipates breakdowns, can manage them when they occur, knows limits of knowledge and how to make referral).

o Virtuoso (acts to the admiration of those who are competent).

o Master (invents/reinvents the domain of action itself)].

B. Emphasis on Community

Community is a significant domain. I'm not sure if it's its own category or might be combined with another. I provide education outside the medical center in the two communities in which I serve: faith-based, and medicine/health care. In the faith community, I have given talks/programs at area synagogues, and at conferences for the NAJC and in Israel. In the medical community, I've given talks at medical conferences on spiritual care. Besides education, there's other work I do in the community. I've helped build a network of connections between the faith-based institutions and my program at the medical center, and between institutions of the Jewish Community. For patients and families, I will make house calls, provide life cycle events (funeral, memorial, baby naming, wedding) when they have no one else to turn to.

In my geographical area, the Bay Area Jewish Healing Center is a community-based program where CPE trained rabbis chaplains to provide spiritual care to individuals at home and in institutions in the community (long-term heath,

hospitals, skilled nursing). There is also a Muslim Chaplaincy (that modeled itself in part after The Jewish Chaplaincy) in California that is a community-based program.

So, in wondering about community, would this be its own category—Provide Community Leadership? Or would you expand a category to "Provide Institutional/Community Leadership"? For example:

o Conceptualize vision for spiritual care that supports and enhances the community and institutions.

o Serve as a resource and point person for moral, ethical and spiritual issues

o Identify opportunities for community and system-wide improvement for healing and justice.

o Conduct services and programs.

o Integrate spiritual care presence and activities at community and institutional events.

G10: Primarily the quality of chaplain leadership within the geographical area, i.e., department directors who make decisions regarding the hiring of chaplains with little experience or lack of certification in order to pay less, incorporate best practices, or advocate for the role of chaplaincy within the organization. There are typically few standards for how chaplains practice across the department. For example, when I was in clinical practice while I had an established role within the service line/units I was assigned to, there was no standardization across the chaplaincy department, so if I was not working, the same quality of or participation in care was not provided. Spiritual assessment is another

example: no standard across the department so while some chaplains provided in-depth per current practice, others would simply document that they had visited and offered prayer. This is true not only in the system that I worked but in all those within my geographical area.

G11: No response.

Finding 3: Interpretation

For Question 1, despite the Panel 5 participant's current role or geographic location, all were unanimous in their assessment that the DACUM profile accurately reflected what health care chaplains did in their region of the United States. For Question 2, despite the Panel 5 participant's current role or geographic location, except for participant G10 from the Southwest, all other participants agreed that the DACUM profile developed in New York transferred to the health care chaplain's role in the five geographical regions. For Question 3, for most Panel 5 participants, participant G9 provided a good summation saying, "Much of my work is encompassed in what you have aptly described in Duty A-I." The exceptions documented were not based on geographic region, but rather current roles, such as director, CPE Supervisor, or Palliative Care Chaplain. For Question 4, for many of the Panel 5 participants, participant G1 provided a good summation saying, "We are also expanding into outpatient chaplaincy and community partnerships as a pastoral care department." The only main variation to G1 would be the change in language that many used: Spiritual Care, as opposed to pastoral care.

Overall, the responses provided by the Panel 5 participants to the four emailed questions indicated that the DACUM profile developed by Panel 1 and validated by

Panel 2 accurately reflected what health care chaplains do in the five geographic regions of the United States. Responses from Panel 5 also indicated that the profile developed in New York transferred to the five geographic regions. The only exception noted were the responses from chaplain G10 who indicated that Southwest chaplains were operating under different guidelines and policies. This was noted but not corroborated by chaplain G11 who also was from the Southwest. When all responses are looked at in total, chaplain G6 provided a good summary view when she wrote in response to question one, "67% (43 of the 67 items) of the duties/tasks in the DACUM Profile align with my role as a health care chaplain. I believe the profile, in general, accurately reflects the role of health care chaplains."

Research Question 2a: Findings

Finding 4: Method of Analysis and Data

Only four tasks where new workers needed training or where veteran workers need training were flagged by at least two Panel 2 participants.

Method of Analysis

One of the steps of the prioritization exercise was to have participants place a green or yellow label on tasks, knowledge concepts, and skills they individually believe require training for new or veteran workers respectively. They do this quietly and independently as discussed in Chapter 3. All six of the panelists participated in the exercise. Each chaplain was given six green labels to distribute over the storyboard, the lists of knowledge concepts and skills for the elements the panelist thought new worker training was needed. The same process was followed for veteran workers using yellow labels.

The analysis was conducted in four steps. First, I reviewed the storyboard and the lists of skills and knowledge concepts for the frequency of occurrence of each element identified by at least one participant indicating new worker training or veteran worker training required. Second, I noted the tasks identified as requiring new worker or veteran worker training by two or more participants. Third, I totaled the number of green and yellow labels assigned to each list and the storyboard. Only those tasks flagged by two or more labels were noted for this analysis to address any special interest bias. Then I calculated frequencies based on all tasks, all knowledge concepts, and all skills. Fourth, I noted the duty bands where the new worker training and veteran worker training tasks identified by two or more participants. The following data support this finding.

There were seven tasks on the storyboard that were flagged by at least one chaplain as requiring new worker training, and 11 tasks were flagged by at least one chaplain indicating veteran worker training was required. When reviewing the list of tasks, only three (4.8%) were selected by two participants, and no task was selected for both new worker training and veteran worker training required by two or more participants.

There were 33 total concepts validated on the knowledge list of which eight were identified by at least one participant indicating new worker training was needed, and three were identified by at least one participant indicating veteran worker training was needed. One of 33 concepts (3.0%) was flagged by three participants for new worker training needed.

There were 27 skills validated of which eight were identified by at least one participant indicating new worker training was needed, and 11 were identified by at least

one participant indicating veteran worker was needed. One of 27 skills (3.7%) was flagged by four participants for new worker training needed. The same skill (3.7%) was flagged by two participants for veteran worker training needed.

The one skill flagged by four participants for new worker training needed and flagged by two participants for veteran worker training needed was Self-care.

Of the three tasks on the storyboard that were flagged by two participants from Panel 2 as requiring new or veteran worker training, all three tasks were selected by two participants. The two tasks requiring new worker training were from the A: Conduct Chaplaincy Encounters duty band while the one task requiring veteran worker training was from the G: Professional Development and Self-Care duty band. The three tasks identified by Panel 2 were A4-Conduct chaplaincy interventions, A7-Document visits, and G7-Contribute to the field through conducting research teaching and publication.

Finding 4: Interpretation

My interpretation of the data collected for Research Question 2a is the participants from Panel 2 did not have a consistent position on which tasks, concepts, and skills required training for new workers or veteran workers. The only two elements that two chaplains flagged for new worker training were two tasks of the duty band A: Conduct Chaplaincy Encounters. My expectation was that each element - tasks, knowledge concepts, and skills would each reach a minimum of 20% of the total of the element flagged by two or more participants. Since that minimum was not reached for any element, it is difficult to define a position or recommendation. My sense of the panel, despite undocumented differences and the fact that several were in positions of authority, was they would exceed the 20% threshold at least for skills and knowledge

concepts. The six who participated did not meet this 20% threshold. I came away with no clear recommendation since the participants from Panel 2 did not have a consistent position on which tasks, concepts, and skills required training for new workers or veteran workers.

Research Question 2b: Findings

Finding 5: Method of Analysis and Data

Panel 2 participants found the DACUM process to be a satisfactory, successful, and challenging process.

Method of Analysis

One of the ways used to monitor the panel's interest and assessment of the process was to administer a basic Level 1 satisfaction survey at the end of each day. The survey (Appendix D) was administered at the end of day 4 for Panel 2.

The first six questions were close-ended questions, using a 5-point Likert disagree-agree scale, and open comment boxes for the remaining questions. These questions were based on this study's research question, and derived from the end of sessions satisfaction questions used by DACUM facilitators trained at Eastern Kentucky University (EKU Facilitation Center, 2011).

Based on the scores registered for each question by the participants, the means and medians were calculated, as shown in Table 18, with an overall mean calculated for the first six questions. The goal was to see if the overall mean would be between 4.25 and 5.00. If the overall mean was in that range, then I would feel comfortable advocating for future DACUMs for chaplains.

The key survey questions which address Research Question 2b were Questions 4 through 9. The following data support this finding.

As shown in Table 18, for the 6 surveys submitted, the overall mean score for the six closed-ended questions was 4.11.

Table 18

Mean Scores from Six End-of-day Survey Questions Completed by Panel 2 Participants on Day 4

Survey Question N = 14	M	Mdn	SD
Q1: I understand the purpose of the research study using the DACUM process.	4.17	4.0	0.41
Q2: I expect the profile that results from this study will positively influence the role of health care chaplain.	4.33	4.0	0.52
Q3: The occupational profile developed so far accurately reflects what I do day-to-day.	4.33	4.0	0.52
Q4: I found the DACUM process to be a good way to develop a profile for a health care chaplain.	4.33	4.0	0.52
Q5: I found the DACUM process to be challenging.	3.33	3.5	0.82
Q6: I found the DACUM process to be a success.	4.17	4.0	0.41
Overall Mean	4.11		

Questions 4, 5, and 6 had the following mean scores. Question 4: I found the DACUM process to be a good way to develop a profile for a health care chaplain had a mean score of 4.33. Question 5: I found the DACUM process to be challenging had a mean score of 3.33. Question 6: I found the DACUM process to be a success had a mean score of 4.17.

Additionally, I reviewed the comments from four of the open-ended questions asked of each respondent.

The following written quotes from the four open-ended, end-of-day survey questions capture the consensus of the Panel 2 participants.

Question 7: The most satisfactory aspect of the DACUM process has been _____.

V1: Seeing what I do each day

V2: Talking with other chaplains

V4: Opportunity to inter-net with peers and work towards a common goal

V5: Opportunity to interact with other chaplains

V6: It was collaborative involving group discussion and exchange of ideas

V7: Interacting with other chaplains

Question 8: The most successful aspect of the DACUM process has been _____.

V1: Identifying areas of focus

V2: Learning what other chaplains do

V4: Helping to identify where improvement is needed

V5: Identifying duties and tasks, elevator speech of/for a chaplain

V6: We did it

V7: Prioritizing tasks I think are important vs. time spent

Question 9: The most challenging aspect of the DACUM process has been _____.

V1: How to say clearly what we do

V2: Being away from job responsibilities

V4: Decision-making

V5: Articulating what we do

V6: Reflecting on my daily work, what I do and what I've had to learn on my own

V7: The stickers

Question 10: What are your thoughts, positive, negative, or neutral about the profile of the health care chaplain developed?

V1: It's accurate though lacks for me something personal/spiritual

V2: I think it is comprehensive

V4: Would be good to hear from recent students or those currently in the process

V5: I felt positive about the profile we developed

V6: Not sure yet

V7: Descriptive and accurate

Finding 5: Interpretation

The overall mean score of 4.11 for survey Questions 1 through 6 and the comments submitted for Questions 7 through 9 indicate that the Panel 2 participants came away with less of a sense of satisfaction and success using the DACUM methodology than was the case for Panel 1. The most satisfying aspect of the process, based on the

respondent comments was the interaction, collaboration, and participation with their peers. The most successful aspect of the process for Panel 2 was the opportunity to learn what others in the role do and to prioritize those duties and tasks. The most challenging aspect of the process was the decision-making process that allowed them to articulate what they do in a concise fashion.

Research Question 2bi: Findings

Finding 6: Method of Analysis and Data

Race, gender, and experience did not influence the health care chaplains' perception of what was satisfactory, successful, or challenging.

Method of Analysis

The method of analysis used for Research Question 2bi was the same method used for Question 2b. The only difference was, for this research question, the focus of the analysis was who said what in the end-of-day survey on Questions 7, 8, and 9. Also, I reviewed my memos and transcripts to identify any themes that would aid the analysis. I also reviewed my member-checking notes and notes I had made during the post-panel interviews.

The following written quotes from three open-ended, end-of-day, survey questions capture the consensus of the Panel 2 participants and support this finding

Question 7: The most satisfactory aspect of the DACUM process has been _____.

V1: Seeing what I do each day

V2: Talking with other chaplains

V4: Opportunity to inter-net with peers and work towards a common goal

V5: Opportunity to interact with other chaplains

V6: It was collaborative involving group discussion and exchange of ideas

V7: Interacting with other chaplains

Question 8: The most successful aspect of the DACUM process has been _____.

V1: Identifying areas of focus

V2: Learning what other chaplains do

V4: Helping to identify where improvement is needed

V5: Identifying duties and tasks, elevator speech of/for a chaplain

V6: We did it

V7: Prioritizing tasks I think are important vs time spent

Question 9: The most challenging aspect of the DACUM process has been _____.

V1: How to say clearly what we do

V2: Being away from job responsibilities

V4: Decision-making

V5: Articulating what we do

V6: Reflecting on my daily work, what I do and what I've had to learn on my own

V7: The stickers

Finding 6: Interpretation

Based on the previous comments, which have been validated with my memos and transcripts, race, gender, experience, and religious affiliation did not appear to influence the participant's perception of what was satisfactory, successful, or challenging regarding

the DACUM process. This might not have been so with a larger panel or a panel made up of chaplains from different regions of the country.

Next, in Chapter 6, I will examine the data, findings, and interpretations from Panels 3 and 4, the CPE Supervisor and the Curriculum Development panels.

Chapter VI

DATA, FINDINGS, AND INTERPRETATIONS FOR RESEARCH QUESTIONS 3 AND 4

Introduction

On day five of the DACUM process, I met with the third panel of participants who were experienced Clinical Pastoral Education (CPE) Supervisors. The purpose of Panel 3 was to review and comment on the profile provided by Panel 1 and reviewed by Panel 2, for potential use in training chaplains. Though Panel 3 met with me for less than a half of a work day, their input was needed to provide a balanced perspective of the profile. The data gathered from Panel 3 along with the profile that was reviewed by Panel 3 was distributed to the members of Panel 4, the curriculum development panel, who met with me several weeks later, to review and comment on the profile and data for potential use by future curriculum developers.

CPE supervisors from Panel 3 contributed their input during the time they met with me and through follow-up emails and telephone calls; the Panel 4 curriculum developers provided their input strictly through a 2-hour web-based meeting. To report the findings from Panels 3 and 4 and address Research Questions 3 and 4, the data, findings, and interpretations for Research Questions 3 and 4 will be reported in this chapter. Table 19 shows a mapping of panels to the research question, a brief description of the panel, the primary modality used for data collection, and the chapter where the data, findings, and interpretations are presented.

Table 19

Panel Descriptions, Logistics, and Panel to Research Question (RQ) Mapping

Panel	RQ	Description	Modality	Chapter
1	1	Initial Panel	In-Person	4
2	2	Validation Panel	In-Person	5
3	3	CPE supervisor	In-Person	6
4	4	Curriculum Development	Web Conf.	6
5	2	Geographically Diverse Validation	Email	5

The outline of the data results and findings for Research Questions 3 and 4 will be:

- Panels 3 and 4 Demographics
- Restate Research Questions 3 and 4
- Panel 3 and 4 Overview
- Research Questions 3 and 4 –Findings
    - Finding 1.0
        - Method of analysis
        - Data Supporting finding
    - Finding 1.0 Interpretation
    - Finding 2.0
        - Method of analysis
        - Data Supporting finding
    - Finding 2.0 Interpretation

    - Etc…(This is only a sample because each research question may have more than two findings.)
- Research Question 3a-Findings etc.
- Research Question 3b-Findings etc.
- Research Question 3bi-Findings etc.
- Research Question 4-Findings etc.
- Research Question 4a-Findings etc.
- Research Question 4b-Findings etc.
- Research Question 4bi-Findings etc.

There is one noteworthy addition to this chapter that was not part of Chapters 4 or 5. This chapter concludes with a summary of major findings indexed by panel. The major findings from each panel will be briefly discussed as a way to consolidate the major findings from this research.

As I did in Chapters 4 and 5, I begin this chapter with a brief discussion of panel demographics. I now present descriptive statistics based on frequencies regarding key Panel 3 and 4 demographics as compiled from the Demographics survey (Appendix C).

Panels 3 and 4 Demographics

Several key demographic descriptors were reviewed from the Demographic Survey because of their relevance to the research questions. These include Gender, Ethnicity, Age, Years as a Chaplain, Religious Affiliation, Ordination Status, Certification Status, Workplace Location, and Title.

Of the four participants on Panel 3, as shown in Table 20, everyone (100.0%) of the participants identified themselves as white or Caucasian, while the panel's average

age was 42 years old. All participants (100.0%) were ordained or had professed their faith per the Roman Catholic rites. One-half of the Panel 3 participants were certified by one of the national certifying organizations. As to religious affiliation, half of Panel 3 (50.0%) self-identified as a member in one of the Jewish organizations, while the other half (50.0%) self-identified as Protestant, or Orthodox respectively. All of Panel 3 participants served in New York City area hospitals, with three serving in Manhattan and one in Queens. Two of the participants had the title of Director, while one self-identified also as a Supervisor. The remaining participant self-identified as a CPE supervisor.

Of the three participants on Panel 4, as shown in Table 20, twice as many were males as females. The majority (66.7%) of the participants identified themselves as white or Caucasian, while the panel's average age was 53 years old. All participants (100.0%) were ordained or had professed their faith per the Roman Catholic rites. The majority of the Panel 4 participants (66.7%) were certified by one of the national certifying organizations. As to religious affiliation, every member of Panel 4 (100.0%) self-identified as a member in one of the Protestant organizations. Participants who spanned two of the defined age ranges and were certified, ordained and represented several of the mainstream Protestant organizations reviewed the profile.

Table 20

Panel 3 and Panel 4 Demographics Summary

	Panel 3 Participants (N = 4)		Panel 4 Participants (N = 3)		Totals (N = 7)
Characteristics	N	Percent	N	Percent	Percent
Gender					
Male	3	75.0	2	66.7	71.4
Female	1	25.0	1	33.3	28.6

Table 20 Continued:

Characteristics	Panel 3 Participants (N = 4) N	Percent	Panel 4 Participants (N = 3) N	Percent	Totals (N = 7) Percent
Ethnicity					
African American	0	0.0	1	33.3	14.3
White or Caucasian	4	100.0	2	66.7	85.7
Eastern European	0	0.0	0	0.0	0.0
Age Distribution					
25-34	2	50.0	0	0.0	28.6
35-44	1	25.0	1	33.3	28.6
45-54	0	0.0	0	0.0	0.0
55-64	0	0.0	2	66.7	28.6
65-74	1	25.0	0	0.0	14.3
75+	0	0.0	0	0.0	0.0
Years As A Chaplain					
No Response	0	0.0	0	0.0	0.0
2-5	1	25.0	0	0.0	14.3
6-10	1	25.0	0	0.0	14.3
11-15	0	0.0	0	0.0	0.0
16-20	2	50.0	1	33.3	42.9
20+	0	0.0	2	66.7	28.6
Ordination Status					
No Response	0	0.0	0	0.0	0.0
No	0	0.0	0	0.0	0.0
Professed	0	0.0	0	0.0	0.0
Yes	4	100.0	3	100.0	100.0
Certification Status					
No Response	0	0.0	0	0.0	0.0
No	2	50.0	1	33.3	42.9
Yes	2	50.0	2	66.7	57.1
Religious Affiliation					
Protestant	1	25.0	3	100.0	57.1
Jewish	2	50.0	0	0.0	28.6
Muslim	0	0.0	0	0.0	0.0
Roman Catholic	0	0.0	0	0.0	0.0
Orthodox	1	25.0	0	0.0	14.3
Quaker	0	0.0	0	0.0	0.0

In summary, after reviewing the demographics of gender, ethnicity, participant age, participant experience, religious affiliation, ordination, and certification status, I

concluded, when compared to Cadge's (2012) sample, that I had a reasonably balanced representation for CPE supervisor and curriculum development review. The curriculum development panel was comprised of all practicing CPE supervisors. A CPE supervisor's scope of responsibility includes not only teaching chaplaincy students but also developing a site-appropriate curriculum that is instructor specific. I was not able to identify any independent curriculum developers for Panel 4 who were not also practicing CPE supervisors. My inability to identify curriculum developers who were not also CPE supervisors was due to the fact that presently CPE supervisors fulfill both the role of a trainer (educator) and curriculum developer. My assumption going into this project was that the curriculum development was performed by a group of CPE professionals who were not also teaching the content. My assumption I learned was incorrect.

Next, I review the third and fourth research questions that provided the foundation for my study of health care chaplains.

Research Questions 3 and 4 Review

In fulfilling this study's purposes, I will answer the following questions:

3. From the perspective of the CPE supervisors, who train chaplains, how well does the final DACUM profile of a health care chaplain meet their needs and expectations?
    a. From the perspective of the CPE supervisors, who train chaplains, what are the strengths and weaknesses of the final DACUM profile?
    b. From the perspective of the CPE supervisors, who train chaplains, which are going to be the most difficult and the easiest components of the final DACUM profile to address in future training interventions?

i. What challenges do the CPE supervisors anticipate implementing the final DACUM profile into future training interventions?

4. From the perspective of the curriculum development panel, how well does the final DACUM profile of a health care chaplain meet their needs and expectations?
    a. From the perspective of the curriculum development panel, what are the strengths and weaknesses of the final DACUM profile?
    b. From the perspective of the curriculum development panel, which are going to be the most difficult and the easiest components of the final DACUM profile to implement into a future curriculum?
        i. What challenges does the curriculum development panel anticipate implementing the final DACUM profile into a future curriculum?

I now present a brief overview of Panels 3 and 4 and my findings.

Panels 3 and 4 Overview

Panel 3 was scheduled to begin at 9:30 AM on day 4 but did not begin until almost 10:30 AM because of travel delays that all participants experienced. I had expected to have six panelists based on my earlier communications. One had a death in the parish that had to be addressed, and another one had a scheduling conflict and was unable to attend. When we got underway, and based on participation, I had four highly intelligent, articulate, caring and vocal participants in the room who completed the review in 2 hours. Despite the panel being made up of a relatively small number of participants with an abbreviated schedule, the panel was interested in reviewing the profile developed

by the Panel 1 and Panel 2 chaplains from the perspective of a CPE supervisor (educator). Once we started and I explained the purpose of this study, everyone's energy was up. I came away from Panel 3 knowing they had provided a candid review of the profile from the educator's perspective.

Panel 4 met for a 2-hour webinar 6 weeks after the validated profile, and associated data (Appendix H) was distributed to the first four panels for review. Panel 4 was unique for three reasons. First, it was the first panel of the five leveraged for this research that did not meet with me in-person. This was a challenge because two of the three participants could not access the webinar because of institutional restrictions. The mitigation strategy used was to simply have a conference call with all participants referencing the distributed profile. Without the video component, it made the session somewhat impersonal. Second, this was the shortest of the sessions, so I had to rely on the panel to thoroughly review the validated profile and associated data prior to our meeting. The panelists all did the required pre-work, which consisted of reviewing the validated profile report, which allowed us to stay focused. The third reason that I found Panel 4 unique was that all participants were not only experienced curriculum developers but also CPE supervisors. Despite the phenomenon of the CPE supervisors also being the curriculum developers, this panel stayed focused on the curriculum development research questions and provided helpful insights into the process and considerations that a curriculum developer who is also a CPE supervisor might use when assessing how to incorporate the profile into their site-defined curriculum.

Now I present a list of my findings for Research Question 3, and it's three sub-questions. The reason why each of these findings became notable will be explained later in this chapter.

Research Question 3: Findings

1. Though the CPE Supervisors thought the profile met their needs and expectations, they were split on which of the job descriptions should be used.

Research Question 3a: Findings

2. The primary strength of the profile according to the CPE supervisor panel is its comprehensiveness, while several weaknesses were identified.
3. The CPE supervisor panel found it interesting that the words prayer and pastoral were omitted from the profile.

Research Question 3b: Findings

4. Four of the top six tasks identified by the CPE supervisor panel as the easiest to teach deal with visiting patients, family, and staff while four of the top six tasks identified as the most difficult to teach deal with outcome oriented chaplaincy and administrative matters.

Research Question 3bi: Findings

5. From the perspective of the CPE supervisors, the main challenge to implementing this profile into future training is the need for additional units to cover all the tasks.

Now I present a list of my findings for Research Question 4, and it's three sub-questions. The reason why each of these findings became notable will be explained later in this chapter.

Research Question 4: Findings

6. The Curriculum Development panel identified the lists of tasks most difficult to teach, most difficult to learn, and the tasks not prepared for in CPE as meeting their needs.

Research Question 4a: Findings

7. The main weakness of the DACUM profile, as pointed out by the Curriculum Development panel, was the lack of adequate representation to support its credibility, whereas the main strength of the DACUM profile was that it was based on the experience of those currently in the field.

Research Question 4b: Findings

8. The tasks easiest to implement in a curriculum were those that CPE supervisors currently focus on such as conduct chaplaincy encounters and facilitate connections, while the tasks most difficult to implement in a curriculum were those that CPE supervisors currently do not focus on such as conduct research and measure outcomes.

Research Question 4bi: Findings

9. The main challenge cited was the need for more time (more units) to address all of the tasks (competencies).

For the remainder of this chapter, I examine each of these findings, one-by-one, the methods used for data analysis, the data supporting the finding, and my interpretation

of the finding and its data. I begin by examining the findings associated with Research Question 3 starting with Finding 1.

Research Question 3 Findings

Finding 1: Method of Analysis and Data

Though the CPE Supervisors thought the profile met their needs and expectations, they were split on which of the job descriptions should be used.

Method of Analysis

The analysis was conducted in two steps. First, I reviewed the distributed profile with the panel and noted main concepts being discussed. Second, I reviewed excerpts from an interaction involving all participants.

The following interaction provides the data that supports this finding.

Facilitator: Now let me take us back to the profile in front of us. How well does the profile meet your needs and expectations as a CPE supervisor? Does it meet your needs?

S3: It meets my needs but is extremely expansive. It needs to be streamlined, or a post-CPE program needs to be developed. Maybe a unit of chaplaincy job training.

S4: Yes, I can work with it but is a lot to cover. A bit intimidating within the boundaries of four units.

S5: It is generally good. It accurately reflects what I expect to teach chaplains.

S6: Yes, I could make it work, but it is a lot to cover. For four units, it is a lot. We might need to consider an extra unit maybe a Master's degree in chaplaincy!

Facilitator: Do you have any thoughts on the two job descriptions?

S3: I like them both.

S4: I like the first over the second. I don't like the sacred space language. I would replace it with a trusting relationship. I would limit the language to healing. I like the breadth of the word healing it encompasses the other terms.

S5: I got tripped up on sacred space. It is far too narrow and does not capture all that I teach. The first description sounds like the chaplains outside job. The first is missing what happens in the room.

S6: I hesitated because I don't like the first. It sounds too mechanical and too focused on administrative stuff. I like the second because it sounds like what I want a chaplain to do. These two reflect the current dichotomy of the time. The first is focused on measured outcomes while the second is not tangibly measurable.

S3: The first (from Panel 1) is more clinical and second (from Panel 2) more pastoral.

S4: The first still addresses what happens in the room using clinical language.

S6: Ok I agree. I can see your point. What concerns me is the language. The whole purpose of a going to a hospital is hope.

Finding 1: Interpretation

Based on the panelist's comments, it is fair to conclude that the CPE supervisors on Panel 3 thought with some defined modifications that the DACUM profile met their needs and expectations as chaplaincy educators. The defined modifications that were referenced included expanding the scope of CPE by either adding a unit to the current four-unit protocol or by streamlining the current requirements.

As part of this discussion on needs and expectations, it seemed quite natural to gauge their opinion of the two job descriptions that were developed by Panel 1 and Panel 2. On the topic of the job descriptions, opinions were divided. Several of the panelists had issues with the term "sacred space" found in the job description developed by Panel 2. Other supervisors had issues with the clinical, non-pastoral language used in the job description developed by Panel 1. What this reflects is two major philosophies currently at work in hospital chaplaincy—those who are advocates of a more historical, pastoral view of the role and those who are more clinically swayed who are advocating outcome-oriented chaplaincy. No decision on which description was preferred was reached in this discussion other than there were differing opinions in play,

Next, I present the second finding from Research Question 3.

Finding 2: Method of Analysis and Data

The primary strength of the profile according to the CPE supervisor panel is its comprehensiveness, while several weaknesses were identified.

Method of Analysis

The analysis was conducted in two steps. First, I reviewed the distributed profile with the panel and noted main concepts being discussed. Second, I reviewed excerpts from an interaction involving all participants.

The following interaction provides the data that supports this finding.

Facilitator: Here is my next question. Could you identify for me the main strength and weakness of the profile?

S3: Absolutely! It captures what is needed, what chaplains do. It is also comprehensive. These descriptors are both its strength and its weakness!

S4: Its' strength is it provides a way, a method, to check my own teaching, in terms of topics and methods. The main weakness revolves around the difference in referencing God in knowledge needed and tasks. God is not mentioned in the tasks, yet God is present on the knowledge needed list.

S6: The main weakness I see is the profile is too vast. One question that I have is, are the demands from administration burning chaplains out?

S5: It is good that is detailed, but it appears that too much time is spent on administration.

Facilitator: Thank you. Good job!

Finding 2: Interpretation

Based on the short exchange that transpired in response to the research question posed to the panel, it is clear from the CPE supervisors vantage point one of the main strengths of the profile was that it was detailed, comprehensive, and captured what chaplains do. Several weaknesses were also cited. As S3 said the comprehensiveness of the profile could also be viewed as a weakness, or as S6 said, the profile "was too vast." The fact that God is not mentioned in the storyboard portion of the profile was mentioned by S4, while S5 and S6 thought it was a profile weakness that chaplains spend a high percentage of their time on administrative tasks. As the facilitator, I am uncertain if the high percentage of time spent on the administrative tasks is necessarily a weakness of the profile, as much as it may have been a wake-up call to the CPE supervisors. It seemed that it was easier for the supervisors to say that the profile had this or that weakness without identifying the root cause of the "administration" issue.

Next, I present the third finding from Research Question 3.

Finding 3: Method of Analysis and Data

The CPE supervisor panel found it interesting that the words prayer and pastoral were omitted from the profile.

Method of Analysis

The analysis was conducted in two steps. First, I reviewed the distributed profile with the panel and noted main concepts being discussed. Second, I reviewed excerpts from an interaction involving all participants.

The following interaction provides the data that supports this finding.

Facilitator: Let me follow-up on an earlier comment made by S4 regarding the use of the word God in the profile. Thoughts anyone?

S4: It is interesting that we don't see prayer in this profile either.

S6: If validation shot down the word pastoral, it does not surprise me that prayer was also edited out. I don't think you can be a responsible chaplain without prayer. It is what people expect from a chaplain. If it is covered under the umbrella of task C5, I am good. We must remember that prayer is an important intervention.

S4: When looking at Duty F I think there are a few connections missing. The connection between the patient and the Divine or the Sacred is one. The second is between the patient and the chaplain. They seem to be absent.

S6: When looking at the list of knowledge concepts needed, it is interesting to see how often God is mentioned here while omitted in the tasks. Theological, sacred texts are well documented here but missing in the storyboard? The tasks seem very secular while the knowledge and skills seem sacred.

S4: Given this discrepancy, it raises the question: is theological education required to be a chaplain?

S3: What makes the role of chaplain unique or necessary? The tasks in this profile could represent any clinical role.

Facilitator: Great insights everyone. Thank you.

Finding 3: Interpretation

The primary point from Finding 3 is that there is a definite issue between those chaplains and supervisors who view the role of health care chaplain as strictly a secular, clinical role and those who view it in a more sacred light. Devoid of sacred language, supervisor S4 voiced a question that will require further study: should theological education be required to be a health care chaplain. If the final response is 'yes,' then the profile should have a more sacred tone. If the role is strictly clinical, to be politically correct, then the profile simply should reflect another clinical role with no reference to the sacred or divine.

Next, I present the fourth finding from Research Question 3.

Finding 4: Method of Analysis and Data

Four of the top six tasks identified by the CPE supervisor panel as the easiest to teach deal with visiting patients, family, and staff, while four of the top six tasks identified as the most difficult to teach deal with outcome oriented chaplaincy tasks and administrative matters.

Method of Analysis

One of the steps of the prioritization exercise is to have CPE supervisors place a white or silver-gray label on tasks they individually believe are easy to teach or difficult

to teach, respectively. They do this quietly and independently as discussed in Chapter 3. All four of the CPE supervisors participated in the exercise. Each participant was given six white labels to distribute over the storyboard for the tasks the panelist thought were easy to teach. The same process was followed for difficult to teach tasks using silver gray labels.

The analysis was conducted in four steps. First, I reviewed the storyboard for the frequency of occurrence of each element identified by at least one participant indicating either that a task was considered easy to teach or difficult to teach. Second, I noted the tasks identified as easy to teach or difficult to teach by two or more participants. Third, I totaled the number of white and silver gray labels assigned to the storyboard. Only those tasks flagged by two or more labels were noted for this analysis to address any special interest bias. Then I calculated frequencies based on all tasks. Fourth, I noted the duty bands where the easy to teach or difficult to teach tasks identified by two or more participants. The following data supports this finding.

There were 16 tasks on the storyboard that were flagged by at least one CPE supervisor as easy to teach, and 13 tasks were flagged by at least one CPE supervisor as difficult to teach. When reviewing the list of tasks, only 10 (15.9%) were selected by at least two participants, and no task was selected as both easy to teach or difficult to teach by two or more participants.

Table 21 provides the data that supports this finding.

Table 21

Top Six Tasks, Identified by the CPE Supervisor Panel as Easiest to Teach and Most Difficult to Teach

Top Tasks Easiest to Teach	Duty Band for Easiest to Teach Tasks	Top Tasks Most Difficult to Teach	Duty Band for Most Difficult to Teach Tasks
Conduct Chaplaincy Interventions	Conduct Chaplaincy Encounters	Measure Outcomes	Conduct Chaplaincy Encounters
Establish Chaplain/Patient/Family/ Saff Connection	Conduct Chaplaincy Encounters	Identify opportunities for system-wide improvement for healing and justice	Provide Institutional Leadership
Practice Self-care	Professional Development and self-care	Create and negotiate department budget	Administration
Conduct Unreferred Visits	Triage Visits	Contribute to the field through research, teaching, and publication	Professional Development and self-care
Document Visits	Conduct Chaplaincy Encounters	Develop Care Plan	Conduct Chaplaincy Encounters
Identify Additional Needs	Conduct Chaplaincy Encounters	Measuring and documenting the impact of chaplaincy care	Administration

Finding 4: Interpretation

Two points are worth mentioning. The first is that the tasks that are the easiest to teach seem to be overwhelmingly populated by tasks having to do with conducting

chaplaincy encounters. The second is that the tasks that are the most difficult to teach have more to do with the business (administration) of a chaplaincy department than what staff chaplains do on a day-to-day basis. Is this because CPE supervisors have been trained to teach one and not the other? Is this enough of a reason to conduct a DACUM analysis of the critical role of CPE supervisor to construct a picture of those that train, educate, and mentor chaplains? Further study seems to be in order if for no other reason than to explain why tasks from Duty A: Conduct Chaplaincy Encounters, such as Measure Outcomes, and Develop a Care Plan are assessed by CPE supervisors as the most difficult to teach and by chaplains as the most difficult to learn as seen in Appendix H.

Next, I present the fifth finding from Research Question 3.

Finding 5:Method of Analysis and Data

From the perspective of the CPE supervisors, the main challenge to implementing this profile into future training is the need for additional units to cover all the tasks.

Method of Analysis

The analysis was conducted in two steps. First, I reviewed the distributed profile with the panel and noted main concepts being discussed. Second, I reviewed excerpts from an interaction involving all participants.

The following interaction provides the data that supports this finding.

Facilitator: As a CPE supervisor, do you think CPE is doing the job it is supposed to do?

S5: There is a disconnect between APC and ACPE. APC believes they're certifying you for hospital chaplaincy, where ACPE believes they're preparing people for ministry not necessarily for chaplaincy.

S4: We as CPE supervisors are very good at communicating and teaching activities that's what we were taught to do, such as didactics and verbatim. What we are never taught to do is how to zoom out and look at the goals and objectives of the program. That's where we wind up falling short. With CPE, we tend to zoom in on the teachable moment, and we would sometimes lose sight of the objective and goal of the program.

S3: I don't think CPE meets our needs. It is a good place to start a good baseline to begin from, but we need to have met a certain baseline level of competence. We also need to have continuing Ed didactics and seminars and retreats to stay sharp and stay up with the field.

S6: I disagree. I believe CPE is just a baseline process and is not intended to give us all the skills we need.

Facilitator: Thank you all. This is all very helpful. Now, based on what you all just said, here is my last question. If this profile of a health care chaplain were to be adopted, from your perspective as a CPE supervisor, what is the main challenge to implementing it?

S3: We would need to have additional units of CPE to address everything that has been identified.

S4: The breadth of it is for me the main challenge. How to teach to all of this. How do you prioritize it all? Since we have focused traditionally on teaching how

to make visits, apparently there is a lot of OJT that we need to incorporate into the training.

S5: No major challenges from my vantage point.

S6: We need post graduate CPE unit(s) plus a more consistent academic acceptance.

Facilitator: Thank you so much for your input into this process.

Finding 5: Interpretation

Based on the CPE supervisors' comments, two points could be construed from the participants. First, there seemed to be some dissatisfaction with CPE by this panel of supervisors. For most, the program did not seem to meet their needs nor expectations. There was an apparent disconnect between two of the certifying bodies, the APC and the ACPE, which has filtered down to those who are on the frontline with student chaplains. This left me wondering if this panel of supervisors was representative of others in the role of CPE supervisor. Second, based on this panel's comments, if the DACUM profile of a health care chaplain was to be incorporated into CPE as it is currently offered, additional units would be required.

I now examine the findings associated with Research Question 4 starting with Finding 6.

Research Question 4 Findings

Finding 6: Method of Analysis and Data

The Curriculum Development panel identified the lists of tasks most difficult to teach, most difficult to learn, and the tasks not prepared for in CPE as meeting their needs.

Method of Analysis

The analysis was conducted in three steps. First, I reviewed the distributed profile with the panel and noted main concepts being discussed. Second, I reviewed excerpts from an interaction involving all participants. Third, I reviewed three of the prioritization lists for the top five tasks identified in each—tasks most difficult to teach (completed by Panel 3), tasks most difficult to learn, and the tasks not prepared for by CPE (completed by Panels 1, 2, and 3).

The top five tasks identified by Panel 3 as most difficult to teach were: Measure Outcomes, Identify Opportunities for System-Wide Improvement for Healing And Justice, Create and Negotiate Department Budget, Contribute To The Field Through Research, Teaching, and Publication, and Develop Care Plan. The top five tasks identified by Panels 1, 2, and 3 as most difficult to learn were: Conduct Spiritual Assessments, Measure Outcomes, Develop Care Plan, Document Visits, Interact with interdisciplinary team(s). The top five tasks identified by Panels 1, 2, and 3 as not prepared for by CPE were: Measure Outcomes, Conduct Spiritual Assessments, Conduct annual performance reviews, Create and negotiate department budget, Initiate and develop Performance Improvement and Quality Improvement.

The following interaction provides the data that supports this finding.

Facilitator: First question: as a curriculum developer, does the DACUM profile meet your needs?

A2: As far as an overview chaplain A1 said it was a thorough report. It was comprehensive and pointed to a lot of good things. Where I got bogged down

was it didn't clearly define what would be the basic unit versus an advanced unit or a residency program.

A1: A lot of stuff in here and to be honest I didn't have time to digest it as thoroughly as I should. What stood out for me is, I really appreciate it was, the ideas that you had shared about those tough to teach and tough to learn. Empathy is not something easy to teach or to learn, and I really appreciated you sharing.

A3: What stands out to me on the page is the pages that deal with topics most difficult to learn and the topics most difficult or not learned in CPE. The top box of those two is basically outcomes oriented chaplaincy. It seems that the APC has basically embraced that model and incorporated into its standards of practice. I'm not sure what to make out of that especially the measure outcomes since that is what APC is using as one of its standards for CPE and what CPE is now preparing students to do.

Facilitator: As a follow-up, would this profile help you as a curriculum developer develop curriculum?

A1: To some degree. Yes, it will help me enhance or improve my program, or add to the curriculum, even though this study was a small sample. Since I don't just service chaplain's, but also supervisors it would help. Do the supervisor's need to know how to do much of what chaplain's do- absolutely. But, this profile is a huge list, and not all could be covered in CPE. ACPE is now struggling with whom they certify. They don't just certify chaplains. They also certify supervisors. Some of what I see in this profile you will never get in CPE you will only get it when you get a job.

A3: Yes, it meets my needs in part as a curriculum developer. It has confirmed some things that I have been thinking about and reading about, and it informs some of the curricula I hope to design, particularly as it relates to assessments, interventions, plans of care, and outcomes. Especially what stands out is the tasks most difficult to learn, the tasks not prepared for by CPE, the tasks most difficult to teach, and the tasks easiest to teach, will inform my design and increase my focus on units on outcome-oriented chaplaincy, preparing people who want to become hospital chaplains.

Facilitator: Thank you all, this is helpful.

Finding 6: Interpretation

The panelists verbally agreed about three summary tables from the prioritization exercises shown in Appendix H and how these tables met their curriculum development needs. Despite this agreement, each panelist who was both an experienced CPE supervisor and curriculum developer shared an episode from their history which left me wondering how well the profile truly met their needs. For example, when A3 said, "Whatever the community focuses on shapes the training, which shapes the practice. The other thing is the flavor of the month." This shows more how each instructor, each region, crafts their own curriculum subjectively. One must ask how entrenched are these educators in the individualistic practice of curriculum development and consequently how well are the student chaplains prepared for their role in the health care system. In summary, I am left wondering if the profile did meet the needs of the curriculum panel.

Next, I present the seventh finding from Research Question 4.

Finding 7: Method of Analysis and Data

The main weakness of the DACUM profile as pointed out by the Curriculum Development panel was the lack of adequate representation to support its credibility, whereas the main strength of the DACUM profile was that it was based on the experience of those currently in the field.

Method of Analysis

The analysis was conducted in two steps. First, I reviewed the distributed profile with the panel and noted main concepts being discussed. Second, I reviewed excerpts from an interaction involving all participants.

The following interaction provides the data that supports this finding.

Facilitator: Next question: as a curriculum developer, what are the strengths and weaknesses of the final DACUM profile?

A3: One is the panels seemed somewhat small in numbers to be truly representative. Two it seems to lack geographic diversity, which I believe you are addressing.

A2: I looked at this and was reviewing the APC Common Standards for Professional Chaplains. What would have helped me is if the profile report was keyed to either the APC Common Standards or the ACPE Objectives. Those are the guidelines I go by. That being said I thought it was very comprehensive.

A3: A strength of this is the DACUM process has been used successfully with other roles. It is a validated tool. Another strength is that you did not consult with the APC standards or ACPE Objectives which did not bias the profile. This came out of the experience of those in the field. Finding the discrepancies

between APC and ACPE and this profile will be helpful to the field and to the leaders of APC and ACPE.

A1: What they said! (Chuckle)

Finding 7: Interpretation

Per the curriculum development panel, the main weakness of the profile was the small sample size used for developing and validating the DACUM profile. The main strength of the profile was, according to the curriculum developers, that it was based on the experience of those currently in the role. There was some discussion as to whether the APC and ACPE standards should have been incorporated or consulted in the profile's development. That was considered but later rejected for two reasons. First, the strength of the DACUM process is that the profile developed is output from the best in the field, reflecting what they do daily. Second, if the health care chaplains' role was ill-defined under the guidance of the APC and ACPE standards, why consult with them? Why not use a method that has not been leveraged to develop a comprehensive occupational profile? Despite the panels being relatively small, the profile developed seems to be viewed as comprehensive even by Panel 4.

Next, I present the eighth finding from Research Question 4.

Finding 8: Method of Analysis and Data

The tasks easiest to implement in a curriculum were those that CPE supervisors currently focus on such as conduct chaplaincy encounters and facilitate connections, while the tasks most difficult to implement in a curriculum were those that CPE supervisors currently do not focus on such as conduct research and measure outcomes.

Method of Analysis

The analysis was conducted in two steps. First, I reviewed the distributed profile with the panel and noted main concepts being discussed. Second, I reviewed excerpts from an interaction involving all participants.

The following interaction provides the data that supports this finding.

Facilitator: From your perspective as a curriculum developer, which are going to be the most difficult and the easiest components of the final profile to implement into a future curriculum?

A2: The list of easiest and most difficult to teach pretty well summarize it for me. Both lists are comprehensive. I would go with them.

A3: The tasks easiest to teach are those that we currently focus on in the curriculum such as conduct chaplaincy encounters, facilitate connections. The difficult ones to incorporate would be the research oriented ones. Under that, I would include measuring outcomes because many of us are not researchers.

A1: I think most that have been identified as critical, and frequently done are teachable and easy to include in a curriculum. Interact with an interdisciplinary team, that a chaplain can approach a doctor or a nurse takes a bit more doing.

Finding 8: Interpretation

The list of tasks that are the easiest to teach and the most difficult to teach as shown in Appendix H and summarized in Table 21 are the tasks the curriculum developers, just like the CPE supervisor panel, have found the easiest and most difficult to implement from the profile. Is this because the curriculum developers have been trained in only a limited number of tasks? This is enough of a reason to conduct a

DACUM analysis of the critical roles of CPE supervisor and curriculum developer to construct a picture of those that train, educate, and develop curriculum for educating chaplains.

Based on what the CPE supervisors and curriculum panels indicate, if the list of tasks that are the most difficult to teach (Appendix H) is an accurate representation of how the supervisors and curriculum developers feel, then it is no wonder that chaplains are saying that research oriented tasks like measuring outcomes are difficult to learn. Based on what the participants, from this panel and from the CPE supervisor panel, said much of the difficulty in teaching the research oriented tasks comes from the fact that neither panel's participants were trained in research methods. Since they were trained in visiting patients, tasks like Conducting Chaplaincy Interventions were easy to teach. If a chaplaincy student gets a supervisor who has been trained in research methods then the chances are the student will be exposed to tasks such as measuring outcomes while if the student happens upon a supervisor who is not versed in research there seems to be a strong possibility that the student will simply be trained in how to conduct patient visits. Since there is no standard curriculum, and supervisors craft a curriculum based on preference and on the site, based on a student's interests they should have the option of which supervisor they would prefer. If this is not considered a solution, then supervisors and curriculum developers need a standard framework for their training and certification before they get in front of students.

Next, I present the ninth finding from Research Question 4.

Finding 9: Method of Analysis and Data

The main challenge cited was the need for more time (more units) to address all of the tasks (competencies).

Method of Analysis

The analysis was conducted in two steps. First, I reviewed the distributed profile with the panel and noted main concepts being discussed. Second, I reviewed excerpts from an interaction involving all participants.

The following interaction provides the data that supports this finding.

Facilitator: Next question: as a curriculum developer, what challenges do you anticipate implementing the final DACUM profile into a future curriculum?

A3: What is becoming crystal clear to me as I hear my fellow curriculum designers discuss this is that there may need to be multiple tracks for CPE. The theological students have a certain set of needs, aspiring hospital chaplains have a certain set of needs, and we have to make a decision when we design a curriculum whose needs we're going to focus on. Since many of these are to be done in hospitals and the focus there is on patients we need to take that into consideration as well. Hospitals are not interested in training theological students. Their main interest is improving the patient experience, etc. etc. All that to say it makes me think that we are going to need multiple tracks with different centers providing the setting for the given tracks.

A2: One of the tasks that I most enjoyed seeing was going from the unconscious to the conscious - interesting. The list of tasks that was most difficult to teach. That almost seemed to be a list that would require a separate course for newly

hired chaplains. For example, policies and procedures, annual performance reviews, budgets, those are the things that the average CPE student gets to be hired would overload them. Once you get hired, and you are on track to become a director or supervisor then those things become more relevant. They are more than we could cover in four units of CPE.

A1: Some of the tasks are just on the job training. You have 400 hours plus the ACPE outcomes. If you add this profile, somethings have to go. In a basic single unit, it seems overwhelming to me. Over the course of a year (pause) maybe.

A2: There are 32-33 knowledge points to cover plus... It is doable but has to make sense and flow toward certification or some other goal.

A3: One of the challenges might be the need to develop a cross-walk between ACPE objectives and what we have here. You could be a risk taker; you could focus more on this as opposed to ACPE outcomes.

A2: The way I have been a risk taker is not to cover every ACPE outcome in every section. In one section I will cover X outcomes, and in another section, I will cover Y outcomes. Whether it is legal or I would get my hand slapped. Over a year, it is the only way I can craft a curriculum that makes sense. It helps me sort all this stuff.

Finding 9: Interpretation

Based on this panel's comments, if the DACUM profile of a health care chaplain were to be incorporated into CPE as it is currently offered, additional units would be required. In retrospect, this raises a host of questions, not the least of which is if the

profile is truly representative of what health care chaplains do and need to know, what are chaplains being taught now in their four units that would block students from being exposed to job-related knowledge, skills, and tasks? As A1 said quite succinctly, "Some of the tasks are just on-the-job training. You have 400 hours plus the ACPE outcomes. If you add this profile, somethings have to go." Since A1 was both a curriculum developer and a CPE supervisor, it is worth noting that this was the main challenge cited by both Panel 3 and Panel 4. If this was the main challenge, the question must then be asked why is it such a challenge if it will prepare students to be health care chaplains?

Next, I will summarize the major findings from each of the five panels discussed in Chapters 4, 5, and 6.

Summary of Major Findings by Panel

Panel 1 Major Findings (Chapter 4)

The first major finding coming out of the first panel was no religion specific duty band was requested or found on the storyboard. Health care chaplaincy today is based on this panel's profile, an interfaith role. As chaplain C8 stated, "We work as generalists and those things we share, but we also work for particular interests and those things we have to do uniquely for our own tradition."

The second major finding coming out of the first panel was: a chaplain is more than what they do; a chaplain is more than a list of tasks. Despite what they said a health care chaplain does in the job description or on the storyboard the dominant theme that emerges from their description of chaplains, is that they are God-oriented people. Based on a documented discussion by the Panel 1 chaplains, chaplains are God-oriented, spiritual people who offer others hope by their presence and by offering them a sacred

space. As chaplain C12 concisely said, "A good part of being a hospital chaplain is who you are not just what you do!"

The third major finding from the first panel was there are gaps in what chaplains do and what CPE has provided in the way of training. A standardized content across all deliveries of CPE is needed. Therefore, one problem with CPE is there is no truly standardized program called CPE with a standardized curriculum. Until such an accepted curriculum is available, there is no way to gauge whether a student chaplain is prepared to serve in the role of staff chaplain.

Panel 2 Major Findings (Chapter 5)

The first major finding that resulted from Panel 2 was the words "pastoral," and "prayer" were removed from the storyboard developed by Panel 1 and validated by Panel 2. As health care chaplains, there is both a need and a trend to avoid the use of traditional sacred language when reflecting on, and describing, what they do daily. Though this may be in opposition to what patients believe the role is about, Panel 2 affirmed quite plainly that even though their training was through the CPE (Clinical Pastoral Education) process, they did not see what they did as pastoral. Reflecting on the language choices arrived at by Panel 2, based on the limited use of traditional sacred terms, the role of health care chaplain seems to have evolved into a secular role within health care.

The second major finding coming from Panel 2 (and Panel 1) was the fact that demographic traits had little influence on the development of the profile. Neither race, gender, experience or religious affiliation seemed to impact the profile. The demographics that may have had some impact on the profile's development were the position each participant currently held and the number of years they were in their current

position. These two demographics on both panels showed some significant variation especially when those who were department directors were examined. On Panel 1 this was evident by one chaplain who was also a senior department director constantly referencing her hospital's strategic plan. On Panel 2 this was also apparent when the panel was asked to rank order the duties and rank the duties by time spent on each. Those who were strictly staff chaplains ranked Duty A, Conduct Chaplaincy Encounters, as most important with the highest percentage of time allocated, while those who were chaplains and department heads ranked Duty E, Administration, as most important with the highest percentage of time allocated. This leads me to advocate for a follow-up study for department heads of chaplaincy departments so that those competencies that department heads require can be identified and incorporated into a standard curriculum.

Panel 3 Major Findings (Chapter 6)

The most significant finding from Panel 3, the CPE supervisors, was the need for additional units to cover all the tasks defined in the DACUM profile. If the DACUM profile of a health care chaplain were to be incorporated into CPE as it is currently offered, additional units would be required. In retrospect, this raises a host of questions, not the least of which is: if the profile is truly representative of what health care chaplains do, and need to know, what are chaplains being taught now that would block them from being exposed to job-related knowledge, skills, and tasks?

Panel 4 Major Findings (Chapter 6)

The most significant finding from Panel 4, and directly addressed one of this studies' purposes, was said by one of the panelists in response to one of the research questions I was asking. The main strength of the DACUM profile was that it was based

on the experience of those currently in the field without consulting APC or ACPE standards.

Panel 5 Major Findings (Chapter 5)

The single major finding that resulted from Panel 5, the geographically diverse validation panel, as discussed in Chapter 5, was that with a few exceptions, the participants from Panel 5 said the profile developed in NYC by Panel 1 and Panel 2 transferred to the five represented geographic regions. Overall, the responses provided by the Panel 5 participants to the four emailed questions indicated that the DACUM profile developed by Panel 1 and validated by Panel 2 accurately reflected what health care chaplains do in the five geographic regions of the United States. For most Panel 5 participants, participant G9 provided a good summation saying, "Much of my work is encompassed in what you have aptly described in Duty A-I."

Chapter VII

SUMMARY, CONCLUSIONS, AND RECOMMENDATIONS

Introduction

In a study done by Flannelly, Handzo, and Weaver (2004) on factors affecting health care chaplaincy, the researchers said, "little research has been done that documents the role chaplains play in health care settings, or the place of chaplaincy and pastoral care with the health care system" (p. 127). This has only been partially addressed in the last 10 years. Until now, there has not been a single, accepted profile of the role. Health care chaplains serve many functions, some of which have been documented or researched to date. De Vries, Berlinger, and Cadge (2008) clearly identify the issue when they say that the specific duties and responsibilities of their job are ill-defined.

The duties and tasks were defined by consensus in this study using a widely used occupational analysis methodology, known as DACUM. DACUM is quick, efficient, and evokes buy-in from leaders and those in a researched role (Norton & Moser, 2008). Adams, Hogan, and Steinke (2015) defined DACUM as "a single sheet skill profile that serves as both a curriculum plan and an evaluation instrument for occupational training programs" (p. 12). The profile that results from a DACUM panel, when validated, can be leveraged by several curriculum design models. These include ADDIE, Successive Approximation, and SCID (Wyrostek & Downey, 2016).

Through this study, a profile was developed by consensus and validated for the role of health care chaplain and recommendations begun for revising the current methods employed for developing curriculum used in Clinical Pastoral Education units.

Problem Statement

The core problem addressed in this research was the need for a systematic articulation of a health care chaplains' competencies, or the duties, tasks, and responsibilities. To date, the role of health care chaplain mostly was based on anecdotal research (Fitchett & Grossoehme, 2011; Handzo et al., 2008; Jankowski, Handzo, & Flannelly, 2011; Lyndes et al., 2012) that led to confusion across the profession.

Heretofore, CPE Supervisors could customize the curriculum for their site based on their style and philosophy. There was no standard, accepted curriculum. Since CPE was the training ground for health care chaplains, students should be exposed to a curriculum and transformative experiences that adequately prepare them for the role. Based on the ACPE Standards (Appendix A) and current practice there was a reason to question whether students were prepared for the role. The reason that role-specific courses were not part of a training curriculum was due to the absence of a clear definition by those in the role. There was a need to thoroughly review the role using a methodology that could be used to develop a profile that lends itself to curriculum development, training delivery, and professional consensus.

Purpose of the Study

The main purpose of the study was to more clearly define the role of a health care chaplain that can be used for training and education and curriculum development, and ultimately to impact and reform clinical pastoral education, which is currently offered

based on site-specific parameters and supervisor specific preferences. A secondary purpose was to discover if a systematic occupational analysis method, such as DACUM, would provide a profile that a cross-section of hospital chaplains would agree accurately represents what they do, and what those who aspire to be chaplains need to know to be successful.

Research Questions

In fulfilling this study's purposes, the following questions were addressed:

1. From the perspective of the initial DACUM panel of health care chaplains, what are the competencies, i.e., duties, tasks, knowledge, skills, traits, and tools, identified for the role of health care chaplain?
    a. From the perspective of the initial DACUM panel of health care chaplains, what knowledge, skills, and tasks are identified as new worker training needs, and veteran worker training needs?
    b. From the perspective of the initial DACUM panel of health care chaplains, what are the most satisfactory, successful, and challenging aspects of the DACUM process?
        i. On the initial panel, how does race, gender, experience, and religious affiliation influence the health care chaplains' perception of what is satisfactory, successful and challenging?
2. From the perspective of the validation DACUM panel of health care chaplains, what are the competencies, i.e., duties, tasks, knowledge, skills, traits, and tools, identified for the role of health care chaplain?

a. From the perspective of the validation DACUM panel of health care chaplains, what knowledge, skills, and tasks are identified as new worker training needs, and veteran worker training needs?
b. From the perspective of the validation DACUM panel of health care chaplains, what are the most satisfactory, successful, and challenging aspects of the DACUM process?
    i. On the validation panel, how does race, gender, experience, and religious affiliation influence the health care chaplains' perception of what is satisfactory, successful and challenging?

3. From the perspective of the CPE supervisors, who train chaplains, how well does the final DACUM profile of a health care chaplain meet their needs and expectations?
    a. From the perspective of the CPE supervisors, who train chaplains, what are the strengths and weaknesses of the final DACUM profile?
    b. From the perspective of the CPE supervisors, who train chaplains, which are going to be the most difficult and the easiest components of the final DACUM profile to address in future training interventions?
        i. What challenges do the CPE supervisors anticipate implementing the final DACUM profile into future training interventions?
4. From the perspective of the curriculum development panel, how well does the final DACUM profile of a health care chaplain meet their needs and expectations?

a. From the perspective of the curriculum development panel, what are the strengths and weaknesses of the final DACUM profile?
b. From the perspective of the curriculum development panel, which are going to be the most difficult and the easiest components of the final DACUM profile to implement into a future curriculum?
    i. What challenges does the curriculum development panel anticipate implementing the final DACUM profile into a future curriculum?

Literature Review

Role-based curriculum development and delivery is impossible to achieve if a profession does not have a clear picture of a role's primary duties and tasks, knowledge, skills and traits (Fortuna, 1996). Fortuna made this crystal clear in her analysis of the medical administrative assistant role in South Florida. An occupational or role analysis has to be conducted for the successful development of role-based curriculum. The curriculum development, training, and assessments must all be synchronized and stand on a foundation of a role's duties and tasks to garner employer and customer confidence in one's skills, abilities, and aptitudes. Fortuna postulated an approach that is systematic to curriculum design is imperative to achieve these goals.

This literature review explored three main concepts that follow the framework described by Norton and Moser (2007). First, I explored the concept of hospital, or health care chaplain along with what is currently known about the role from different perspectives. Second, I examined the concept of Clinical Pastoral Education, and how chaplains currently are educated. Third, I reviewed the concept of occupational analysis,

and why the DACUM process for occupational analysis has been used for roles other than health care chaplains.

Chaplain's Role

The role of the health care chaplain is changing from what it was historically and depending on whom you ask, or how you interact with a hospital chaplain will color your understanding of the role of chaplain (Mowat & Swinton, 2007).

In order to gain an understanding of the role of health care chaplain, the traditional understanding of the role was first explored. Per Mowat and Swinton (2007), a chaplain traditionally represents a community of faith and works in a setting that is specific. In Scotland, this is the way hospital chaplaincy developed. The chaplain provides pastoral services to an institution, agency, organization, or entity. The services may include worship, ministry to those in crisis, sacraments, counseling, support for the staff and community. Ryan (1997) describes the role of chaplains in helping people to be whole persons, no matter their life circumstance.

De Vries, Berlinger and Cadge (2008) clearly articulate a common understanding of today's health care chaplains. "Chaplains offer a supportive presence that serves to remind patients and caregivers that people are more than just their medical conditions or their current collection of concerns" (de Vries, Berlinger & Cadge, 2008, p. 23). A chaplain's focus is to read the whole person, asking questions about peoples' lives outside the hospital.

Despite this understanding of the role of a health care chaplain, many believed the role needed further research and definition. Berlinger (2008), in describing professionalizing hospital chaplains, says that chaplains have a difficult time articulating

what they do. This is problematic in the day of the outcome-based initiatives in health care institutions. Norwood's (2006) outstanding expose on the ambivalent chaplain described the problems that are faced in understanding the current role. The role of hospital chaplain is at a crossroads between structural differences that worship medical forms of power and those of the religious order. According to Norwood, chaplains are bridging the medical space and the space of religion, alternately embracing one space or the other. Jankowski, Handzo, and Flannely (2011) acknowledge that the research to date is inadequate in defining what chaplains do that is unique to the practice of chaplaincy. This has caused an ambivalence in the profession and in understanding the role.

Role of CPE

Clinical Pastoral Education (CPE) is the method traditionally used to deliver the training to those interested in health care chaplaincy (ACPE, 2010). CPE is offered in a variety of organizational settings including hospitals, long-term care facilities, prisons, hospices, rehabilitation centers, and local communities of faith. Hemenway (1982) says the goal of CPE is to promote students' growth into a professional identity and ability to function in ministry while enabling them to grow through practical opportunities into self-knowledge and self-use. According to Hemenway, those who are trained educators for CPE units are said to be certified CPE supervisors. They are traditionally ordained members of the clergy or chaplains who are ecclesiastically endorsed by a religious body. The supervisors are trained in psychology, the theories of education, and group dynamics.

CPE is an educational methodology that merges understanding of psychology with theological knowledge and the processes of how we learn, to prepare seminarians, clergy, and qualified laity for the interfaith and social complexities of the modern world,

including those found in health care (Hemenway, 2005). Hemenway (1996) in a study of what it is like to be inside the CPE circle says, the "educational methodology in CPE has been inconsistent, causing confusion among ourselves and our students" (p. vii).

DACUM

Robert Adams describes DACUM as a "single sheet skill profile that serves as both a curriculum plan and an evaluation instrument for occupational training programs. It is graphic in nature, presenting definitions of the skills of an entire occupation" (Adams, 1975, p. 24). According to Norton (1992), the main reason for using DACUM as expressed by educators and trainers is that it provides a relevant, up-to-date, data source for curriculum development and for instructional programs. A data source for curriculum development that is maximally based on local business and industry input is needed to ensure that the training provided and developed is aligned with business' expectations and requirements. According to Johnson (2010), "most methods of job analysis rely on indirect sources of data, while the DACUM method relies directly on the workers themselves to describe and define their jobs" (p. 32). These experts, through facilitation, reach a consensus on a role that a wider population of those in the role validate, which helps in gaining buy-in for the profile across the occupation and the subsequent curriculum (Norton & Moser, 2008). DACUM addresses what individuals in an identified role should be taught, and should learn (Dennison, 1995; Norton & Moser, 2008).

According to Norton and Moser (2008), a 2-day DACUM workshop involves 5-12 expert workers from a role, occupation, job or position along with a trained facilitator. They say that the deliverable from that workshop is a detailed and graphic profile chart

displaying detailed duties and tasks that comprise the role. Comprehensive lists of knowledge, skills, and traits are also identified for the role.

Cooper, Aherne, and Pereira (2010) selected DACUM to address the need for Professional Hospice Palliative Care Spiritual Care Provider (HPC) focused clinical education. In their research, they found DACUM's strengths to be its ability to target the core tasks of the role and what those in the role, and those who want to be in the role, need to learn. They concluded their report by saying that the DACUM profile for this role provided a formal contribution to a growing global discussion about the role's responsibilities, and tasks, and would benefit those interested in this role, including certifying bodies and those developing a clinical training curriculum.

Summary

O'Brien (1989b) in his study of health occupation education programs said, the "DACUM technique can be used to examine virtually any occupation, regardless of technical complexity, or level of responsibility" (p. 59). He goes on to speak about panels made up of members from specialty groups in health care. This addresses the panels for this research study, which were made up of chaplains from different religious backgrounds and environments, a type of specialty group in health care. O'Brien, (1989b) says, "the resulting DACUM chart would be comprehensive in nature and would provide an adequate base for curriculum development" (p. 66).

Methods and Procedures

Research Design

A mixed methods case study approach, with an emphasis on qualitative methods, was selected for this study. The reason was that the selected approach was well suited for

exploring unique cases that have little or no research associated with them such as the case with the role of health care chaplain (Creswell & Plano Clark, 2011; Fetters et al., 2013)

In this study, I examined a cross-section of chaplains in the metropolitan New York area, affiliated with The HealthCare Chaplaincy Network, which collaborates with a number of health care institutions in the New York City area and several cities across the United States. I wanted to see if the DACUM process can be used to generate an accurate occupational profile of the profession. To ensure greater accuracy two panels reached consensus on a profile that represented what health care chaplains do and need to know to function successfully in health care settings today. In addition, I assessed if a panel of curriculum experts and a panel of Clinical Pastoral Supervisors who train chaplains can use the profile to develop curriculum and deliver training for future learning interventions. Finally, the profile was distributed to a panel of 10 chaplains that were stationed within the five geographic regions of the United States, two per region, to assess if the profile developed in New York City translated well to their current locations.

Protocol Followed

Following the Eastern Kentucky University DACUM model, a DACUM analysis that could be used for curriculum development required four focus groups. This model called for an initial focus group with representative panel members, who are experts in the role, selected by agency staff. Once the initial profile was developed, it was presented to a second group of experts in the role, not included in the initial panel, for comments, edits, additions and deletions, and validation. A formal leadership or management review was then conducted by a third group. The final product was then

presented to a curriculum development team for feedback on the design and development capabilities. One modification was made to the EKU model to address the issue of geographic generalizability. To the four standard panels, a fifth was added to validate the profile across the five major regions of the United States.

Applying the modified EKU model to this study, the five panels were (a) Panel 1 - an initial DACUM panel of health care chaplains, (b) Panel 2 - a validation DACUM panel of health care chaplains, (c) Panel 3 - a panel of CPE supervisors (educators) which took the place of the leadership review in the generic model, (d) Panel 4 - a panel whose focus is curriculum development, and (e) Panel 5 - a geographically diverse validation panel of health care chaplains.

Sampling

The members of each panel were purposefully selected by an industry expert using criterion standards to guide the final selection (Patton, 2002). Panel 1 was composed of a cross-section of nine experts within the health care chaplain role from the New York Tri-State area. Panel 2 was composed of six experts within the health care chaplain role from the New York Tri-State area. Panel 3 was composed of four experts within the CPE supervisor role from the New York Tri-State area. Panel 4 was composed of three experts within the CPE supervisor role who were also expert curriculum developers. Panel 5 was composed of 11 experts within the health care chaplain role; two each from the Northeast, Southeast, Southwest and West and three from the Mid-West.

To identify the panelists, I worked with an industry expert, the Senior Director of Chaplaincy Services and Clinical Education of The HealthCare Chaplaincy Network. He identified chaplains who fulfill the following criteria: have 2 years or more experience

and represent a cross-section of chaplains based on race, gender, and religious affiliation. His selections were cross-checked by the Director of Health Services, Research, and Quality. The chaplains were selected as High Performing Incumbent Workers (EKU Facilitation Center, 2011), who are experienced in their role and who were willing to verbally participate in the sessions. These panelists had real-world knowledge of what health care chaplains do on a day-to-day basis. The goal was a balanced representation of men and women, races and ethnicity, and religious affiliations so that the final profile represents what a typical health care chaplain does and needs to know from this geographic region. The goal for the selection of participants was to achieve a cross-section of experienced health care chaplains, supervisors and curriculum developers based on race, gender, and religious affiliation, and chaplains.

Data Collection

As Maxwell (2013) recommended, multiple methods of data collection were used to provide a means of validation via triangulation. In addition, multiple methods of data collection enabled the study of different aspects of the role of health care chaplain. The sources of data collection for this mixed methods study were (a) focus groups in the form of DACUM panels, (b) interviews, (c) email-based surveys, and (d) facilitator journal memos including photo documentation of the profile evolution.

Data Analysis

As there were multiple methods used to collect data for this study, there were multiple methods of analysis used. Data analysis was going on at the same time as data collection was occurring. The analysis included reviewing over 48 hours of interview transcripts, panel transcripts, observational notes, and journal notes and memos using

thematic coding. Analysis of the profile's development using profile notes and a photo journal was a second step in the analysis. Profile notes and a photo journal helped explain which duty bands were representative of all participants and which duty bands were representative of a subset of participants. For example, there were duties and tasks that changed dramatically from the initial panel to the validation panel. The analysis is part of the protocol followed by DACUM facilitators trained at Eastern Kentucky University. Asking questions like why this dramatic change occurred, and what are the implications for training and curriculum development were key to understanding the final profile and addressing the research questions. Finally, statistical frequencies from the prioritization coding exercises were analyzed.

As Maxwell (2013) recommended, listening to recorded interviews and reading interview transcripts should be one of the first analytical methods used from the outset of this study. Memos and notes were written, and initial categories and tentative relationships identified during this initial analysis step. After listening and reading, transcripts and memos were thematically coded and categorized. Links between themes were identified. The protocol that was used for the analysis of DACUM panel recordings, interviews, recorded web-based meetings, memos, journal and observational notes, and profile notes is the seven-step process advocated by Creswell (2014).

Validation

Interpretations of the interview data, and the journal and observational notes, were validated primarily using member checking (Creswell, 2014). Member checking was used to determine the accuracy of the findings and interpretations by taking back to six of the participants' significant parts of the transcripts, such as major findings and themes, to

solicit feedback about the data and interpretations. Member checking was an important technique that helped to rule out the "possibility of misinterpreting the meaning of what participants say and do" (Maxwell, 2013, p. 126). Member checking was also a valuable method of identifying my biases while ensuring that participants' positions were accurately represented. In addition to member checking, two senior level researchers, not affiliated with the study, were asked to review portions of the data for their interpretation. Consulting with two senior level researchers provided an unbiased perspective and determined what was misinterpreted, what was completely missed, and what may have been interpreted correctly.

Major Conclusions

The following sections include an outline of the major conclusions that came from this research. First, a statement of the conclusions about the DACUM profile developed during this study, then the role of a health care chaplain is discussed, followed by the conclusions concerning CPE and, finally, the conclusions about the use of DACUM.

This Study's DACUM Profile

The main purpose of the study was to define the role of a health care chaplain that can be used for training and education and curriculum development. To that end, the purpose was satisfied by means of generating a validated, comprehensive DACUM profile that consisted of two diverse job descriptions; a graphical storyboard detailing the duties and tasks that chaplains perform; a comprehensive list of concepts that a health care chaplain needs to know; lists of skills, traits, and tools that chaplains need to have; along with prioritized lists of tasks that are critical to the role, frequently done by those in the role, and in which new and veteran chaplains need training. The DACUM profile

was initially generated by a panel of nine chaplains over the course of 3 days, and then reviewed, edited and validated by a second panel of chaplains on the fourth day. This validated profile was then sent out across the U.S. for review and overall acceptance by 11 other chaplains.

The validated graphical storyboard was made up nine duties and 63 tasks distributed over those duties. Despite the use of some traditional sacred terms, such as *prayer* and *pastoral*, in the initial storyboard, the validated profile does not have a single instance of either term as a duty or a task. The main thing that the validated profile reveals is that as health care chaplains there is both a need and a trend to avoid the use of traditional sacred language when reflecting on, and describing what they do daily. Though this may be in opposition to what patients believe the role is about, Panel 2 affirmed quite plainly that even though their training was through the CPE (Clinical Pastoral Education) process, they did not see what they did as pastoral. Reflecting on the language choices arrived at by Panel 2, based on the limited use of traditional sacred terms, the role of health care chaplain seems to have evolved into a secular role within health care.

This is in sharp contrast to the *Common Standards for Professional Chaplaincy* (2004) whose core domains rely on the term *pastoral* using the term 24 times in articulating four domains and 29 competencies. If these are the "Common Standards" they may need to be redrafted 13 years later to reflect the changing profession. Another possible reason for the difference between the "Common Standards" and this studies profile could be the lack of a standardized curriculum which focused on the "Common Standards." Or if the "Common Standards" are widely accepted, the possibility exists

that the DACUM profile generated by this study does not accurately reflect the profession on a wider scale. Future DACUM studies on a regional basis would help to clarify this difference.

Chaplain's Role

The primary conclusion regarding the role of a health care chaplain, coming from this study, is the reason that there is confusion about the role is because those in the role had not been consulted about the duties and tasks performed by a chaplain on a daily basis. Though the chaplains on Panel 1 and Panel 2 were quite clear about what they did on a daily basis, there were enough differences between the two to conclude that there are two schools of thought currently within chaplaincy. There is a historical, pastoral school of thought that advocates prayer, presence, and the use of sacred language and ritual, and a modern, spiritual school of thought that advocates more on the side of the health care institutions served through research, outcome-oriented results or what has been labeled evidence-based chaplaincy. Both schools of thought are represented in the final profile as well as in the two job descriptions that were developed. Though the two panels reviewed the final products and gave them their blessing, I still think that the tension between the two schools will need to be discussed by the certifying bodies to reach consensus, and provides sufficient grounds for additional regional studies to confirm or refute the profile developed in New York City.

A secondary reason why the role of health care chaplain has the tension brought about by two schools of thought is the result of there not being a standard curriculum used in their training. As CPE supervisor – Curriculum Developer A3 said, the curriculum is often swayed by the flavor of the month, referring in this case to

transformational learning. The non-standardization of the curriculum used in training health care chaplains is a major reason there is confusion regarding the role of a health care chaplain. Whether one school dominates the curriculum, or both are given equal footing, is inconsequential. What matters is the consistent delivery of a standardized curriculum.

CPE

The main conclusion regarding the role of CPE and CPE supervisors impact on the role of health care chaplains has to do with a CPE supervisors' scope of responsibility. According to Jones (2010), just as there is confusion over the role of chaplain, there is confusion over the role of CPE supervisor and what that means from an educational perspective.

What happens now is non-standard curriculum is developed and delivered by supervisors, who are not trained as curriculum developers but create instruction that is consistent with their view of the role of health care chaplains. If there is confusion and inconsistency among CPE supervisors, this might explain the confusion over the role and responsibility of health care chaplains (Hemenway, 1996).

My impression, from the five panels that participated in this study, is that the real bottleneck to developing a clear profile of the role of health care chaplain is due to the inconsistent training practices and methods used during CPE training. Without a standardized framework that is grounded in what a health care chaplain does daily, there is currently no way that chaplain A trained in a rural center in South Georgia, will receive the same training nor be as equipped for the variety of situations as chaplain B who is trained in an urban center in San Francisco. Even if both chaplain A and B had the same

CPE supervisor, since CPE is currently site specific and based on the predilections of the supervisor, the training would be different.

This inconsistent training model is exacerbated by the fact that apparently, the CPE supervisors are also the curriculum developers. Simply stated based on this training model there is no formal CPE training program. If there was such a formal program, a chaplain trained at one center by one supervisor would receive equivalent training if trained by any other supervisor at any other center. Either the curriculum becomes standardized by a team of CPE supervisors who are subject matter experts in collaboration with trained curriculum developers, or the role of health care chaplain will continue in a state of confusion.

By supporting two major roles with poorly defined responsibilities, it becomes apparent that much of the confusion regarding the role of health care chaplain could be resolved if the role of CPE supervisor and CPE curriculum developer were better defined and understood.

DACUM

The primary conclusion drawn from this study regarding the DACUM method used is that it was well received by all of the panels, provided an abundance of data, and was well suited for the role of health care chaplain. According to comments from Panels 4 and 5, one of the best features were the lists that resulted from the prioritization exercises which identified the tasks most difficult to teach, tasks most difficult to learn, and the tasks not prepared for by CPE. The three metrics were add-ons to the standard EKU prioritization exercise which traditionally only identifies tasks that are critical, frequently done, or in which new or veteran workers need training. Overall, if more

occupational analyses for the role of health care chaplains are required in the future, DACUM, as modeled at EKU, would be a method worth considering.

Recommendations

The following sections contain a list of recommendations that came from this research. First stated are recommendations about the role of a health care chaplain, followed by the recommendations concerning CPE and finally the recommendations for using DACUM.

Chaplain's Role

Four recommendations for further study are the result of the research conducted on the role of health care chaplain conducted in this study. Despite the value of the data gathered from Panel 5, the geographically diverse validation panel, comments were made by several participants that led me to recommend that several regional DACUM studies be conducted. Multiple regional DACUM studies would help identify consistencies and potential variances among health care chaplaincy practices nationwide. Especially of value would be an analysis of rural chaplains from several regions and suburban chaplains.

The second recommendation for further study is to conduct several DACUM studies of those serving as directors of chaplaincy or spiritual care departments. From the several directors on the panels who were also chaplains, it was clear to many on the panels that they had different responsibilities than a staff chaplain. Those responsibilities would demand a curriculum that addressed their competencies.

The third recommendation would result after all DACUM studies were completed. A task analysis should be conducted on the role to develop the learning

objectives for a standardized curriculum. Where DACUM helps define the duties and tasks performed by chaplains, a task analysis helps to define how the duties and tasks are performed, step-by-step. Based on the task analysis learning objectives would be defined that would provide the first step towards a curriculum framework. With clearly defined learning objectives, an assessment blueprint would be crafted that if accepted could be rolled into a well-defined, hierarchical, certification program containing both cognitive and performance-based elements. This process would be applicable to junior chaplains, senior chaplains, directors, etc.

Finally, the fourth recommendation comes from Panel 3. A study needs to be conducted to explore whether theological study should be required for the role of health care chaplain. If hospitals are not interested in training theological students, but mainly interested in outcomes, the question must be explored if theological training is needed for health care chaplains.

CPE

The main recommendation for CPE that comes from this study is that several nationwide DACUM studies should be conducted on the role of the CPE supervisor. If the role of a health care chaplain is confused because non-standard approaches are taken by CPE supervisors, it could be because of the lack of a standard curriculum used to train CPE supervisors. In addition, one or more DACUM studies should be conducted on the role of those developing curriculum for CPE. If all CPE supervisors are developing curriculum, then the DACUM for the CPE supervisors may contain one or more duty bands that explicitly address those tasks. If all CPE supervisors are not developing curriculum, then the role of CPE curriculum developer needs to be examined.

DACUM

The primary recommendation for the DACUM methods used in this study is that an experienced panel of curriculum developers be assembled, along with a panel of CPE supervisors and a panel of expert health care chaplains, to draft a standard curriculum for health care chaplains based on the profile that resulted from the current study. The curriculum could leverage a blended approach that would be both cognitive and performance based. The development of this curriculum could become the foundation for certifying health care chaplains and result in the role being recognized by other professions.

A secondary recommendation for the EKU DACUM methods used in this study is that a study should be conducted to explore whether or not input from ancillary groups should be incorporated into the profile. Normally, a profile is created and validated by resources in the same role. According to the EKU process, the validated profile could then be reviewed and edited by one or two management panels.

Since the CPE supervisors and curriculum developers were leveraged not as management, but to assess the profiles value for training and curriculum development, their recommendations were recorded but not incorporated. The question then arises should their feedback have been incorporated even though they were not directly managing the chaplain? Would this violate the value of the DACUM profile developed by those in the role who are the subject matter experts for the role?

Since the CPE supervisors and curriculum developers would be directly impacted by the profile, the case could be made that their input was critical. However, with the underlying confusion about the role of a health care chaplain and the further confusion

concerning the role of the CPE supervisor, another case could be made that the CPE supervisor input would have negatively impacted the profile.

The argument for incorporating the input from ancillary groups could be taken a step further by advocating for input from the patients who may be directly impacted by the final profile and the training that results. A study should be conducted to explore whether or not input from ancillary groups should be incorporated into a profile developed using the EKU DACUM method.

Summary:

Two issues emerged because of this study. First, now CPE Supervisors generally customize the curriculum for their site based on their style and philosophy. There is no standard curriculum for training health care chaplains. That could be changed if the role definition of the health care chaplain that has been developed by this study was accepted. If CPE is the training ground for health care chaplains, students should be exposed to a curriculum and transformative experiences that adequately prepare them for the role. Up to this study, a major reason that role specific courses were not part of a training curriculum was because the role was not defined by those in the role. According to Norton and Moser (2008), the best resources to define what is done in a role are those experts in the role.

Second, since the goal of CPE is broader than training health care chaplains, there should be role-specific training and certification paths within CPE for those wishing to be parish leaders, military chaplains, rabbis, or work in pastoral and family counseling, or health care chaplains. The solution could be as simple as a curriculum path and certification roadmap that is role specific and addresses each roles' duties and tasks.

From this study and the literature, it appears that CPE is trying to be all things to all roles and thus, the role of health care chaplain has not been granted a professional status and has never had clarity within modern-day health care. Furthermore, since health care chaplains are often certified, based on Denominational (religious) affiliation, the findings of this study will impact the certification roadmaps published for chaplains by the major certifying organizations: the APC, the NACC, the NAJC, and the ACPE.

A DACUM on the role was a step in the direction of standardization. From it, with follow-up studies, the curriculum may be standardized and brought into line with the current published standards. The role of health care chaplain has taken a step towards being clarified in this study by addressing the issue of role-confusion that existed.

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APPENDIX A:

2010 ACPE Objectives and Outcomes for a Basic Unit of CPE

In the 2010 Standards Manual, the Association of Clinical Pastoral Education says a unit of CPE enables pastoral formation, pastoral competence, and pastoral reflection. It defines the objectives and outcomes for a basic, introductory unit of CPE, what is called a Level 1 unit.

Pastoral Formation Objectives

•to develop students' awareness of themselves as ministers and of the ways their ministry affects persons.

•to develop students' awareness of how their attitudes, values, assumptions, strengths, and weaknesses affect their pastoral care.

•to develop students' ability to engage and apply the support, confrontation and clarification of the peer group for the integration of personal attributes and pastoral functioning.

Pastoral Competence Objectives

•to develop students' awareness and understanding of how persons, social conditions, systems, and structures affect their lives and the lives of others and how to address effectively these issues through their ministry.

•to develop students' skills in providing intensive and extensive pastoral care and counseling to persons.

•to develop students' ability to make effective use of their religious/spiritual heritage, theological understanding, and knowledge of the behavioral sciences in their pastoral care of persons and groups.

•to teach students the pastoral role in professional relationships and how to work effectively as a pastoral member of a multidisciplinary team.

•to develop students' capacity to use one's pastoral and prophetic perspectives in preaching, teaching, leadership, management, pastoral care, and pastoral counseling.

Pastoral Reflection Objectives

•to develop students' understanding and ability to apply the clinical method of learning.

•to develop students' abilities to use both individual and group supervision for personal and professional growth, including the capacity to evaluate one's ministry.

Pastoral Formation Outcomes

•articulate the central themes of their religious heritage and the theological understanding that informs their ministry.

•identify and discuss major life events, relationships and cultural contexts that influence personal identity as expressed in pastoral functioning.

•initiate peer group and supervisory consultation and receive critique about one's ministry practice.

Pastoral Competence Outcomes

•risk offering appropriate and timely critique.

•recognize relational dynamics within group contexts.

•demonstrate integration of conceptual understandings presented in the curriculum into pastoral practice.

•initiate helping relationships within and across diverse populations.

Pastoral Reflection Outcomes

•use the clinical methods of learning to achieve their educational goals.

•formulate clear and specific goals for continuing pastoral formation with reference to personal strengths and weaknesses (p.13-15).

APPENDIX B:

HealthCare Chaplaincy Network CPE Core Curriculum

Preamble: Unity within diversity is HealthCare Chaplaincy's approach to CPE. The unifying component is adherence to the CPE Objectives as outlined in the ACPE Standards. Out of these standards flow the fourfold elements of our theoretical model:

1. Theology

2. Community

3. Clinical Pastoral Skills

4. Personal and Pastoral Development

HealthCare Chaplaincy's unique quality and quantity of diversity is implemented at each CPE site by faculty and students with diverse religious, ethnic and cultural backgrounds. The process conception of learning permeates the curriculum through the use of many experiential learning models such as contract for learning, interpersonal relations seminars, Verbatims, theological reflection papers, didactics, and group and individual supervision.

I. Core: Theology

A. To learn and demonstrate competence in use and understanding of prayer and other religious resources and learn to understand the impact of faith traditions on illness and health.

B. To learn theological reflection in the matrix between one's espoused theology and operational theology in the face of clinical experience and to learn to assess the spiritual experiences in one's own life and the lives of those to whom one ministers.

C. To learn the art of spiritual assessment and how to implement this into treatment plans.

D. To learn to articulate clinical data through theological lenses and incorporate this into ministry specialty projects.

II. Core: Community

A. To learn sensitivity and empathy in regards to racial, religious, ethnic, gender, and sexual orientation and to articulate issues arising in a multi-cultural, multi-faith, and pluralistic setting.

B. To learn to challenge and support peers in ministry, to be challenged and supported by peers, and to learn to practice effective leadership.

C. To learn to collaborate with other professional communities within the clinical milieu and to initiate collaborative relationships within interdisciplinary settings.

D. To learn to worship and share faith journeys in a multi-faith community and to initiate and design worship experiences in a multi-faith setting.

E. To learn to identify needs and to demonstrate and initiate pastoral care of self and others in community.

III. Core: Clinical Pastoral Skills

A. To learn facilitative listening.

B. To learn to identify feelings and meanings and to respond empathetically.

C. To learn to discern and evaluate pastoral relationships.

D. To learn to develop and design a pastoral care plan.

E. To facilitate storytelling and to hear the meta-story.

F. To learn to use self as a primary tool of pastoral care.

G. To learn to access and mobilize the patient's religious resources in the face of suffering.

H. To learn one's abilities and limitations and to work within these parameters.

I. To learn the art of referral to professionals from other disciplines.

J. To learn to articulate the chaplain's role within the multidisciplinary team.

K. To learn to articulate one's personal theology of pastoral care.

L. To learn to relate effectively and collaboratively with community clergy and faith group visitors.

IV. Core: Personal and Pastoral Development

A. To learn to tell, claim and utilize one's personal story for self-understanding and for use in pastoral relationships.

B. To learn to identify and articulate strengths and weakness as person and pastor.

C. To learn to identify and explore personal emotional dynamics in order to understand their impact on others; how to develop empathy; how to relate appropriately to others.

D. To learn different roles and models of pastoral care.

E. To demonstrate competence and maturity as a pastoral caregiver and to take appropriate leadership in a variety of settings.

Note to the student: Your CPE supervisor has a specific syllabus and specific course requirements for your group at the hospital to which you are assigned. Each supervisor's syllabus and curriculum varies and is based on the CPE supervisor's curriculum, style and philosophy of supervision. The syllabus and curriculum that you will be given at the start of your CPE program is site specific (personal communication, July 16, 2013).

APPENDIX C:

Demographic Survey

Healthcare Chaplains DACUM Analysis -1- Demographics

Demographics

You are being asked for basic demographic information. Your identity will be kept anonymous and you will be assigned a code during the first hour of your participation.

***1. Which of the following Anonymous Codes has been assigned to you?**

- C1
- C2
- C3
- C4
- C5
- C6
- C7
- C8
- C8
- C9
- C10
- C11
- C12
- V1
- V2
- V3
- V4
- V5
- V6
- V7
- V8
- V9
- V10
- V11
- V12
- S1
- S2
- S3
- S4
- S5
- S6
- S7
- S8
- S9
- S10
- S11
- S12
- A1
- A2
- A3
- A4
- A5
- A6

***2. What is your gender?**

- Female
- Male

Healthcare Chaplains DACUM Analysis -1- Demographics

***3. What is your ethnicity? (Select all that apply)**

- African
- American Indian or Alaskan Native
- Asian or Pacific Islander
- Black or African American
- Eastern European
- Hispanic or Latino
- White / Caucasian
- Prefer not to answer
- Other (please specify) _____

***4. What is your age?**

- 18 to 24
- 25 to 34
- 35 to 44
- 45 to 54
- 55 to 64
- 65 to 74
- 75 or older

Healthcare Chaplains DACUM Analysis -1- Demographics

***5. What is the highest level of school you have completed or the highest degree you have received?**

- Less than high school degree
- High school degree or equivalent (e.g., GED)
- Some college but no degree
- Associate degree
- Bachelor degree
- Master's degree
- D.Min.
- Ed.D
- Ph.D.
- Th.D.
- Other (please specify)

***6. What is your religious affiliation?**

- Agnostic
- Atheist
- Buddhist
- Christian Scientist
- Jewish
- Mormon
- Muslim
- Orthodox, such as Greek or Russian Orthodox
- Protestant
- Roman Catholic
- Seventh-Day Adventist
- Other (please specify your specific affiliation, e.g. Orthodox Jewish, Lutheran-ELCA)

Healthcare Chaplains DACUM Analysis -1- Demographics

Role Specific

***7. Are you a healthcare chaplain?**

- Yes
- No
- Other (please specify)

***8. What is your current title?**

***9. Which healthcare site/hospital / organization do you currently serve?**

***10. Which of the following accurately describes your current healthcare/organization setting? (Select all that apply)**

- Urban
- Sub-urban
- Rural
- Upstate New York
- Manhattan
- Bronx
- Brooklyn
- Queens
- Staten Island
- New Jersey
- Pennsylvania
- Connecticut
- Other (please specify)

Healthcare Chaplains DACUM Analysis -1- Demographics

***11. What type of hospital / healthcare / organization setting do you work at? (Select all that apply)**

- [ ] General Hospital
- [ ] Long Term Care Center
- [ ] Specialty Center
- [ ] Surgery Center
- [ ] HCC Corporate Office
- [ ] Public
- [ ] Private
- [ ] Faith-based (affiliated with a religious organization)
- [ ] Teaching Center
- [ ] Non-teaching Center
- [ ] Other (please specify)

***12. How many years have you been a healthcare chaplain? (Include all years since you entered CPE.)**

- [ ] 0
- [ ] <1
- [ ] 2-5
- [ ] 6-10
- [ ] 11-15
- [ ] 16-20
- [ ] 20+
- [ ] Other (please specify)

Healthcare Chaplains DACUM Analysis -1- Demographics

***13. Apart from experience as a chaplain, how many years professional experience do you have serving in a religious role? (Serving as a priest, nun, pastor, minister, imam, rabbi, monk, brother, sister, etc.)**

- 0
- <1
- 2-5
- 6-10
- 11-15
- 16-20
- 20+

***14. Have you been ordained by a religious organization?**

- Yes
- No
- Not Yet

Other (please specify)

***15. Have you received certification as a chaplain?**

- Yes
- No
- Provisional
- Not Yet
- Not Applicable

Other (please specify)

Healthcare Chaplains DACUM Analysis -1- Demographics

***16. If you have been certified, which of the following organizations have you been certified by? (Select all that apply)**

- ACPE
- APC
- CPSP
- NACC
- NAJC
- Not Yet
- Not applicable
- Other (please specify)

***17. Are you a CPE Supervisor?**

- Yes
- No
- Other (please specify)

***18. How many years have you been a CPE Supervisor/Educator?**

- 0
- <1
- 2-5
- 6-10
- 11-15
- 16-20
- 20+
- Not applicable
- Other (please specify)

Healthcare Chaplains DACUM Analysis -1- Demographics

***19. Are you affiliated with the HealthCare Chaplaincy Network? (Do you work for HCCN?)**

- Yes
- No
- Other (please specify)

***20. Are you a Curriculum Developer/ Instructional Designer / Course Developer?**

- Yes
- No
- Not applicable
- Other (please specify)

***21. How many years have you been involved in Curriculum Development?**

- 0
- <1
- 2-5
- 6-10
- 11-15
- 16-20
- 20+
- Not applicable
- Other (please specify)

***22. If you are a health care chaplain, is health care chaplaincy a second career for you?**

- Yes
- No
- Not applicable
- Other (please specify)

Healthcare Chaplains DACUM Analysis -1- Demographics

Participation

***23. Based on the information provided to you, are you willing to participate on the initial panel?**

- Yes
- No
- Not applicable
- Other (please specify)

***24. Based on the information provided to you, are you willing to participate on the validation panel?**

- Yes
- No
- Not applicable
- Other (please specify)

***25. Based on the information provided to you, are you willing to participate on the CPE Supervisor panel?**

- Yes
- No
- Not applicable
- Other (please specify)

***26. Based on the information provided to you, are you willing to participate on the curriculum development panel?**

- Yes
- No
- Not applicable
- Other (please specify)

APPENDIX D:

End-of-Session Survey

Healthcare Chaplains DACUM Analysis -End of Day Evaluation

End of Day Feedback

Based on today's session, please respond to the following questions / statements using the scale provided, or by providing your written feedback.

This will help to improve future sessions

***1. I understand the purpose of the research study using the DACUM process.**

- 1- Strongly Disagree
- 2- Disagree
- 3- Neither Agree or Disagree
- 4- Agree
- 5- Strongly Agree

***2. I expect the profile that results from this study will positively influence the role of health care chaplain.**

- 1- Strongly Disagree
- 2- Disagree
- 3- Neither Agree or Disagree
- 4- Agree
- 5- Strongly Agree

***3. The occupational profile developed so far accurately reflects what I do day-to-day.**

- 1- Strongly Disagree
- 2- Disagree
- 3- Neither Agree or Disagree
- 4- Agree
- 5- Strongly Agree

***4. I found the DACUM process to be a good way to develop a profile for a health care chaplain.**

- 1- Strongly Disagree
- 2- Disagree
- 3- Neither Agree or Disagree
- 4- Agree
- 5- Strongly Agree

Healthcare Chaplains DACUM Analysis -End of Day Evaluation

***5. I found the DACUM process to be challenging.**

- 1- Strongly Disagree
- 2- Disagree
- 3- Neither Agree or Disagree
- 4- Agree
- 5- Strongly Agree

***6. I found the DACUM process to be a success.**

- 1- Strongly Disagree
- 2- Disagree
- 3- Neither Agree or Disagree
- 4- Agree
- 5- Strongly Agree

***7. The most satisfactory aspect of the DACUM process has been _____.**

***8. The most successful aspect of the DACUM process has been _____.**

***9. The most challenging aspect of the DACUM process has been _____.**

***10. What are your thoughts, positive, negative, or neutral about the profile of the health care chaplain developed?**

Healthcare Chaplains DACUM Analysis -End of Day Evaluation

*11. If this process was repeated in the future, with other panels of health care chaplains, what recommendations to the process would you like to see implemented?

APPENDIX E:

Marketing Brochure for Participants

A Call for Participants

WARREN E. WYROSTEK, M.Div., M.Ed in Collaboration with The HealthCare Chaplaincy Network

- **Research Project Title:** *A DACUM Analysis of Health Care Chaplains in Metro NY and The Implications for Clinical Pastoral Education*
  - A Study in Partial Fulfillment of the Ed.D. at Valdosta State University.
- **Purposes of the Study:**
  - To develop the profile for the role
  - To validate or recommend revisions to the currently deployed curriculum used in Clinical Pastoral Education
- **Needs:**
  - Experienced Chaplains, CPE Supervisors and Curriculum Developers who are willing to participate voluntarily and contribute their view of the role of health care chaplain.
- **Benefit:**
  - Using a time-tested research process, you will have an opportunity to clearly articulate what chaplains do and need to know
  - An opportunity to shape the role and perception of a health care chaplain
  - An opportunity to help determine what new chaplains and veteran chaplains need training in – to help define future CPE Curriculum
- **Process:**
  - Initial Face-to-Face Panel with 10-12 Experienced Chaplains who can speak to the day-to-day duties and tasks of a health care chaplain in a facilitated focus group format.
  - Validation Face-to-Face Panel with 5-6 Experienced Chaplains who will validate the initial Panel findings.
  - CPE Supervisor Face-to-Face Panel with 5-6 Experienced CPE Supervisors with will validate the Panel's findings from an Educators point-of-view.
  - Curriculum Development Panel with 5-6 Experienced Curriculum Developers who will review the Panel's findings from an Instructional Design point-of-view by means of a web conference.
  - Non HCCN Geographically Diverse Validation Panel with 5-10 Experience Chaplains, 1-2 from each of 5 major geographic regions in the U.S. to review the final profile for applicability to their geographic region by email exchange.
- **Time Requirements:**
  - 3 days for the initial panel at the HCCN Office
  - A half day for the validation panel at the HCCN Office
  - A half day for the CPE Supervisor panel at the HCCN Office

- 2 hours for the Curriculum Developer's panel-- a WebEx Video Conference -Time to be determined
- 2 hours for the Geographically Diverse Panel to correspond by email

- **Contact for more Information:**
  - Warren E. Wyrostek, Researcher: wewyrostek@valdosta.edu

APPENDIX F:

Institutional Review Board (IRB) Approval and Consent Forms

Institutional Review Board (IRB)
for the Protection of Human Research Participants

NEW PROTOCOL APPROVAL

PROTOCOL NUMBER: **IRB-03132-2014** **RESPONSIBLE RESEARCHER:** **Warren Wyrostek**

PROJECT TITLE: **A DACUM Analysis of Healthcare Chaplains**

APPROVAL DATE: **11/13/14** **EXPIRATION DATE:** **11/13/15**

LEVEL OF RISK: ☒ Minimal ☐ More than Minimal

TYPE OF REVIEW: ☒ Expedited Under Catetory/ies :6&7 ☐ Convened (Full Board)

CONSENT REQUIREMENTS:

- ☒ Adult Participants – Written informed consent with documentation (signature)
- ☐ Adult Participants – Written informed consent with waiver of documentation (signature)
- ☐ Adult Participants – Verbal informed consent
- ☐ Adult Participants – Waiver of informed consent
- ☐ Minor Participants – Written parent/guardian permission with documentation (signature)
- ☐ Minor Participants – Written parent/guardian permission with waiver of documentation (signature)
- ☐ Minor Participants – Verbal parent/guardian permission
- ☐ Minor Participants – Waiver of parent/guardian permission
- ☐ Minor Participants – Written assent with documentation (signature)
- ☐ Minor Participants – Written assent with waiver of documentation (signature)
- ☐ Minor Participants – Verbal assent
- ☐ Minor Participants – Waiver of assent
- ☐ Waiver of some elements of consent/permission/assent

APPROVAL: This research protocol is **approved** as presented. If applicable, your approved consent form(s), bearing the IRB approval stamp and protocol expiration date, will be mailed to you via campus mail or U.S. Postal Service unless you have made other arrangements with the IRB Administrator. Please use the stamped consent document(s) as your copy master(s). Once you duplicate the consent form(s), you may begin participant recruitment. **Please see Attachment 1 for additional important information for researchers.**

COMMENTS:

Lorraine Schmertzing *11/13/14*

Lorraine Schmertzing, Ed.D., IRB Chair Date

Thank you for submitting an IRB application.

Please direct questions to irb@valdosta.edu or 229-259-5045.

Form Revised: 12.13.12

NEW PROTOCOL REVIEW REPORT
Attachment 1

ADDITIONAL INFORMATION FOR RESEARCHERS:

If your protocol received expedited approval, it was reviewed by a two-member team, or, in extraordinary circumstances, the Chair or the Vice-Chair of the IRB. Although the expediters may approve protocols, they are required by federal regulation to report expedited approvals at the next IRB meeting. At that time, other IRB members may express any concerns and may occasionally request minor modifications to the protocol. In rare instances, the IRB may request that research activities involving participants be halted until such modifications are implemented. Should this situation arise, you will receive an explanatory communiqué from the IRB.

Protocol approvals are generally valid for one year. In rare instances, when a protocol is determined to place participants at more than minimal risk, the IRB may shorten the approval period so that protocols are reviewed more frequently, allowing the IRB to reassess the potential risks and benefits to participants. The expiration date of your protocol approval is noted on the approval form. You will be contacted no less than one month before this expiration date and will be asked to either submit a final report if the research is concluded or to apply for a continuation of approval. It is your responsibility to submit a continuation request in sufficient time for IRB review before the expiration date. If you do not secure a protocol approval extension prior to the expiration date, you must stop all activities involving participants (including interaction, intervention, data collection, and data analysis) until approval is reinstated.

Please be reminded that you are required to seek approval of the IRB before amending or altering the scope of the project or the research protocol or implementing changes in the approved consent process/forms. You are also required to report to the IRB, through the Office of Sponsored Programs & Research Administration, any unanticipated problems or adverse events which become apparent during the course or as a result of the research and the actions you have taken.

Please refer to the IRB website (http://www.valdosta.edu/ospra/HumanResearchParticipants.shtml) for additional information about Valdosta State University's human protection program and your responsibilities as a researcher.

VALDOSTA STATE UNIVERSITY

Consent to Participate in Research

You are being asked to participate in a research project entitled "A DACUM analysis of health care chaplains in Metro New York and the implications for clinical pastoral education." This research project is being conducted by Warren E. Wyrostek, a student in The College of Education at Valdosta State University. The researcher has explained to you in detail the purpose of the project, the procedures to be used, and the potential benefits and possible risks of participation. You may ask the researcher any questions you have to help you understand this project and your possible participation in it. A basic explanation of the research is given below. Please read this carefully and discuss with the researcher any questions you may have. The University asks that you give your signed agreement if you wish to participate in this research project.

Purpose of the Research: This study involves research. The purpose of the study is to define the role of a health care chaplain that can be used for training and education and curriculum development and ultimately to impact and reform clinical pastoral education which is currently offered based on site specific parameters and supervisor specific preferences.

Procedures: You are being asked to participate in 1 of 5 panels that consist of experienced health care chaplains, clinical pastoral educators, or curriculum developers. The process that you will participate in is known as DACUM. The DACUM process has a long history of being used in the United States and Canada in industry, university and health care for

occupational role definition. To date it has not been used to define the role of a health care chaplain.

You are only being asked to participate in one panel.

As an expert in the field of health care chaplaincy, clinical pastoral education, and/or curriculum development, you will be asked to candidly and openly share what you do in your role and your perception of the developing/developed profile of a health care chaplain with those on your panel and the facilitator. Through a dotting exercise you will also be asked to identify those tasks, knowledge, and skills that are critical to the role, frequently done by those in the role, difficult to learn, difficult to teach, and that new workers and veteran workers need training on. Prior to your panel meeting you will be invited to attend a 1-hour Overview of the study by means of a Web Conference. Attendance is optional.

You will be asked to fill out a Demographic Survey at the beginning of your panel, at which time you will be assigned an anonymous code. At the end of each day's session, you will also be asked to complete an End of Day Feedback Survey to assess the process.

After the first four panels complete the development of the profile of a health care chaplain, you will be asked to provide one-on-one feedback and to validate the researcher's impressions, by means of a telephone interview that will be scheduled at a mutually convenient time with the researcher.

The five panels that will be used for this research and their time commitments are the following:

Number	Name	Number of pants	Modality	Time ement	Follow Up one Interview
1	Initial Panel	10-12	In Person at Care Chaplaincy 65 Broadway, Y 10006	3 days: y to Friday ~9-4:30 PM	1 hour to ent each pants' ment of the ofile and to e any cher sions.
2	Validation Panel	5-12	In Person at Care Chaplaincy 65 Broadway, Y 10006	1/2 to 1 day: Thursday ~9-1PM with tion of going he	1 hour to ent each pants' ment of the ofile and to e any cher sions.

3	CPE Supervisor	5-12	In Person at Care Chaplaincy 65 Broadway, Y 10006	1/2 to 1 day: Friday ~9-1PM with tion of going he	1 hour to ent each pants' ment of the ofile and to e any cher sions.
4	Curriculum per Panel	5-12	WebConference VebEx	2 hours: imately 2 after the first panels de	Optional 1 elephone ew
5	Geographically e Validation Non-Panel	5-10	Email Exchange	1-2 hours to the final imately 4 after first panels are de.	Optional 1 elephone ew

Possible Risks or Discomfort: Since this study basically involves participants sharing what they do in their job as a health care chaplain there is no known risk or discomfort. Although there are no known risks associated with these research procedures, it is not always possible to identify all potential

risks of participating in a research study. However, the University has taken reasonable safeguards to minimize potential but unknown risks.

By agreeing to participate in this research project, you are not waiving any rights that you may have against Valdosta State University for injury resulting from negligence of the University or its researchers.

Potential Benefits: As an experienced health care chaplain, clinical pastoral supervisor, or curriculum developer, you have the opportunity through this process to shape the professions' understanding of what chaplains do and what chaplains need to know to perform their duties . Although you may not benefit directly from this research, your participation will help the researcher gain additional understanding of the role of health care chaplain. Knowledge gained may contribute to addressing some of the documented gaps in Clinical Pastoral Education.

Costs and Compensation: Apart from public transportation costs to the HCCN office for those participating in in-person panels, there are no costs to you and there is no compensation for your participation in this research project. Your voluntary participation is greatly appreciated.

Assurance of Confidentiality: Valdosta State University and the researcher will keep your information confidential to the extent allowed by law. Members of the Institutional Review Board (IRB), a university committee charged with reviewing research to ensure the rights and welfare of research participants, may be given access to your confidential information.

Audio recordings, survey data, transcripts, etc. will retained in the researchers' home office under lock and key and only the researcher will have access to it. Digital data and files will be encrypted with a strong password which only the researcher will have possession of. All raw data will be retained for up to three years from the time of the final report in order to comply with Federal IRB regulations. Raw data will be ultimately destroyed by shredding for hard copies or digitally deleted and overwritten for soft copies.

Before, during and after the study, all participants will only be referred to by their assigned anonymous code. The map for names to anonymous codes will be kept in a password protected Microsoft Excel Workbook for no longer than 3 years after data in final report format is published. After 3 years the file will be digitally deleted and overwritten.

Aggregate data from this study will be reported and published, but names will be anonymized.

Voluntary Participation: Your decision to participate in this research project is entirely voluntary. If you agree now to participate and change your mind later, you are free to leave the study. Your decision not to participate at all or to stop participating at any time in the future will not have any effect on any rights you have or any services you are otherwise entitled to from Valdosta State University.

For the Demographic and End of Day Feedback Surveys you may skip any questions that you do not want to answer.

Should you decide to withdraw after data collection is complete, your information will be deleted from the database and will not be included in research results.

Information Contacts:

Questions regarding the purpose or procedures of the research should be directed to Warren E. Wyrostek at 850-929-2074 or wewyrostek@valdosta.edu. This study has been approved by the Valdosta State University Institutional Review Board (IRB) for the Protection of Human Research Participants. The IRB, a university committee established by Federal law, is responsible for protecting the rights and welfare of research participants. If you have concerns or questions about your rights as a research participant, you may contact the IRB Administrator at 229-333-7837 or irb@valdosta.edu.

Agreement to Participate: The research project and my role in it have been explained to me, and my questions have been answered to my satisfaction. I agree to participate in this study. By signing this form, I am indicating that I am 18 years of age or older. I have received a copy of this consent form.

I would like to receive a copy of the results of this study: _____ Yes_____ No

Mailing Address: _____

email Address: _____

This research project has been approved by

the Valdosta State University Institutional Review

_____

Printed Name of Participant

_____

Signature of Participant Date

_____

Signature of Person Obtaining Consent Date

IRB-03132-2014

Exp: 11/13/15

APPENDIX G:

Sample Photo Journal Distributed to All Participants for Validation

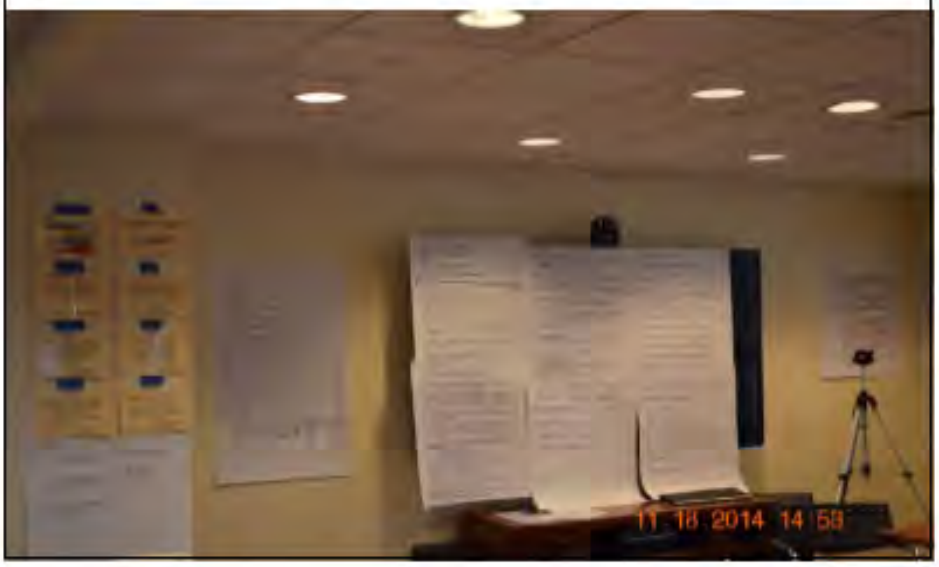
A DACUM Analysis of Health Care Chaplains in Metro New York and the Implications for Clinical Pastoral Education-Photo Album

Warren E. Wyrostek, M.Div., M.Ed.

11/17/14-11/21/14

The Beginning-Prior to Profile Development

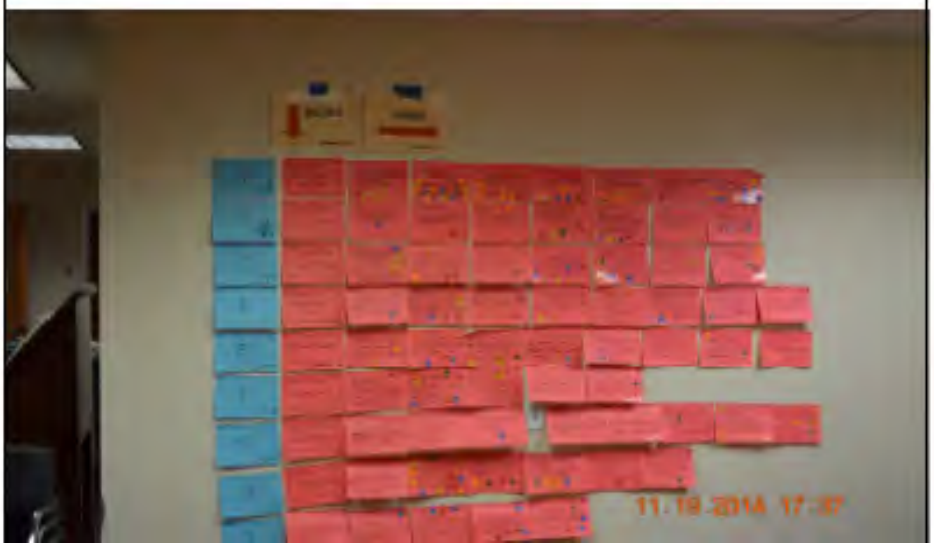
Initial Profile- The Job Description and the Lists of Duties and Tasks Take Shape



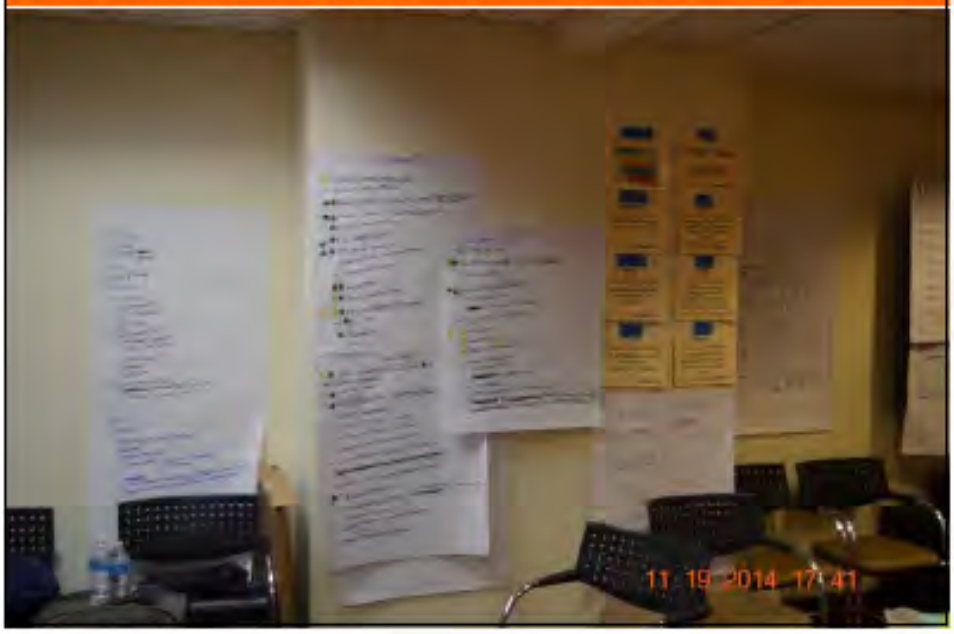
Initial Profile-The First Duty Bands Are Defined-We Have A Storyboard

Initial Profile-In Development

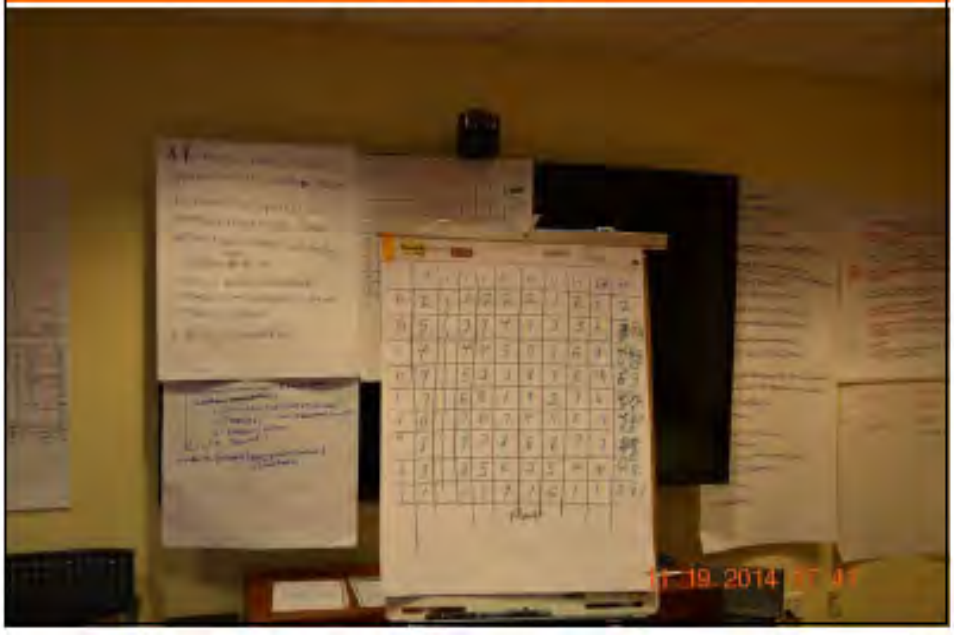
Initial Profile-With Dotting Exercise Applied- Next Step Validation



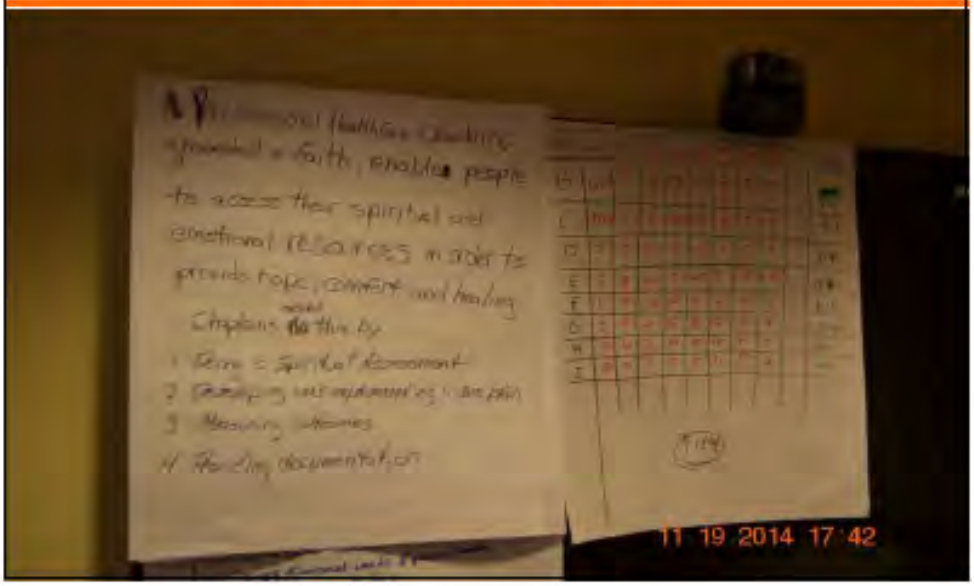
Initial Profile-Knowledge and Skills with Training Needs Dots Applied



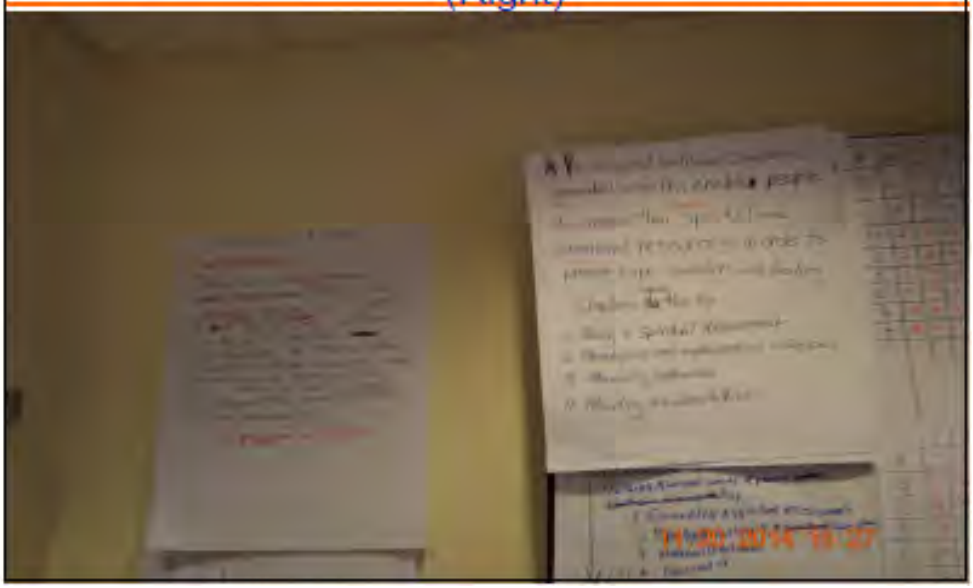
Initial Profile-A lot of DATA and a Full Profile in 3 Days



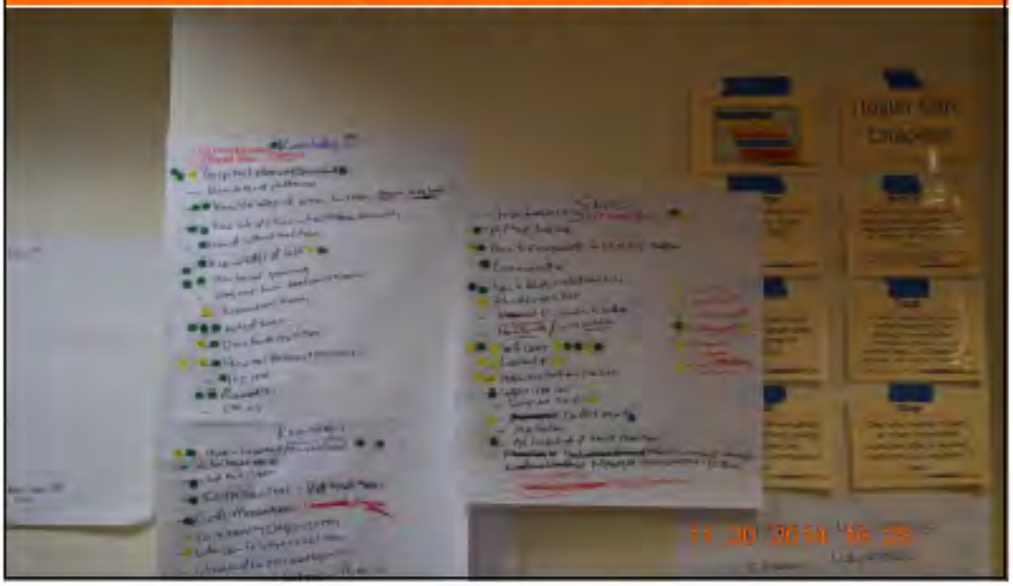
Initial Profile- The Job Description of a Health Care Chaplain



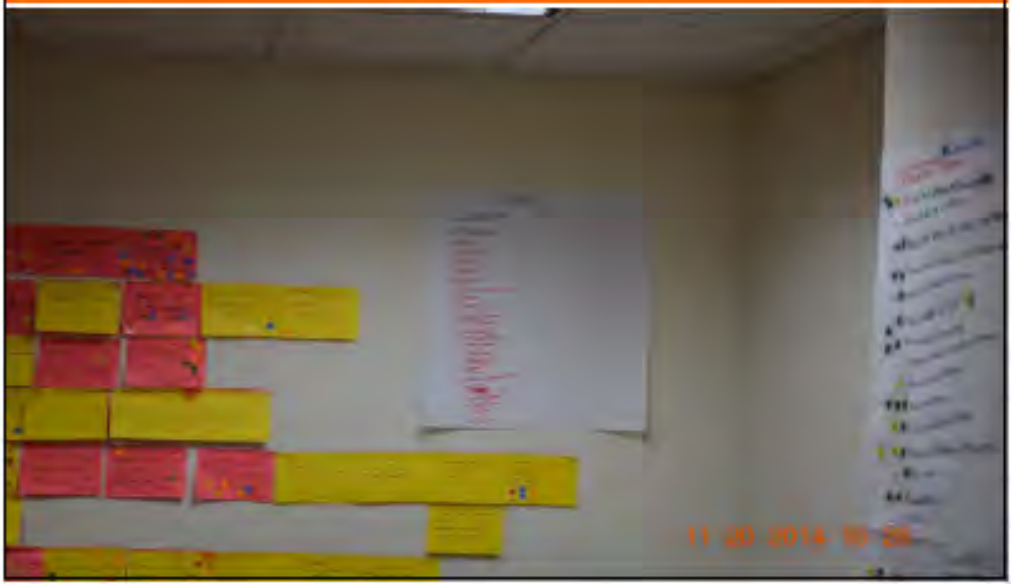
Validation Panel-With a Job Description (Left) that varies from the Initial Panel's Description (Right)



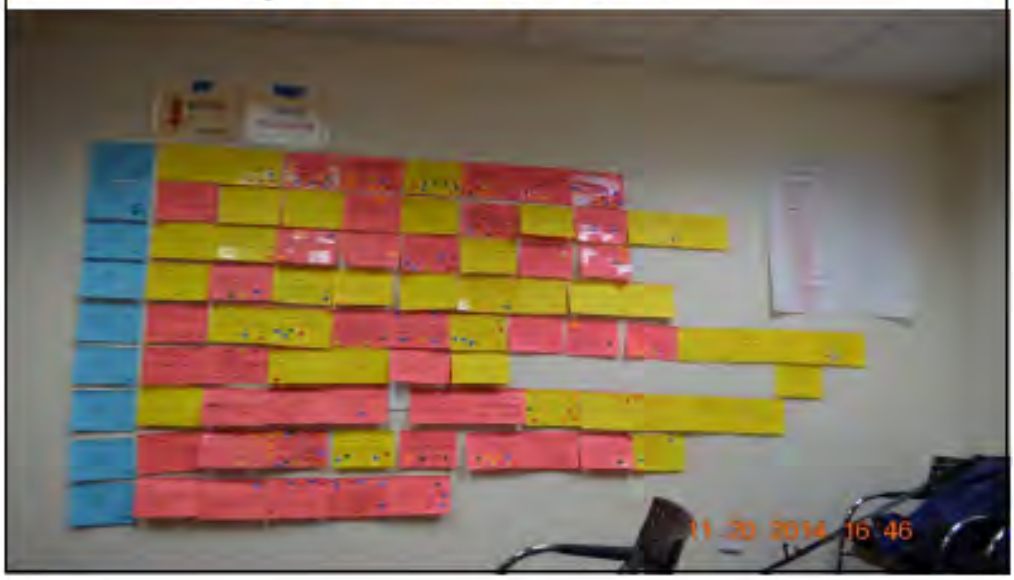
Validation Panel-Knowledge and Skills with Training Needs Dots Applied



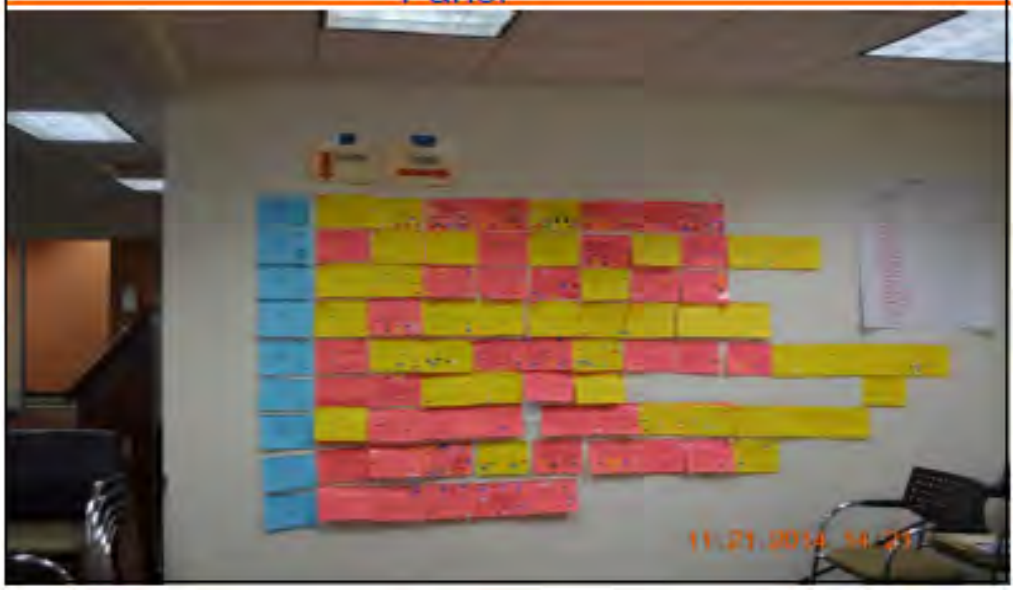
Validation Panel- Completed the List of Tools



Initial and Validation Panel Storyboard Yellow Post-Its Indicate Changes Made by the Validation Panel



Final Storyboard- The Result of the Initial, Validation, and CPE Supervisor Panel



Final Storyboard- A Close-up of 6 of the Duty Bands

APPENDIX H:

Report Sent to All Participants for Review and Validation

Occupational Profile
OF

Health Care Chaplain

PREPARED FOR

Valdosta State University
HealthCare Chaplaincy Network

Warren E. Wyrostek,-
Facilitator, Researcher and
Ed.D. Candidate
Sharon Fletcher-Recorder

Panels

Initial 11/17/14-11/19/14
Validation 11/20/14
CPE Supervisor 11/21/14
Curriculum Development 4/14/15
Geographical Diverse Panel 4/11/15-
5/15/15

DACUM OCCUPATIONAL ANALYSIS
The DACUM process incorporates the use of a focus group in a facilitated storyboarding process to capture the observations of high performing incumbent workers regarding the major duties and related tasks included in an occupation.

BY
WARREN E. WYROSTEK,
M.Div.,M.ED.

Introduction

Study Title: A DACUM ANALYSIS OF HEALTHCARE CHAPLAINS IN METRO NEW YORK AND ITS' IMPLICATIONS FOR CLINICAL PASTORAL EDUCATION

Researcher: Warren E. Wyrostek, M.Div., M.Ed., ABD (In partial fulfillment of the Ed.D. at Valdosta State University

IRB: 03132-2014

Panels:

• Initial	11/17-19/2014	N=8
• Validation	11/20/2014	N=6
• CPE Supervisors	11/21/2014	N=4
• Curriculum Developers	4/14/2015	N=3
• Geographically Diverse	4/11/2015-5/15/2015	N=9-10

Purpose of the Study: The purpose of the study is to define the role of a health care chaplain that can be used for training and education and curriculum development and ultimately to impact and reform clinical pastoral education which is currently offered based on site specific parameters and supervisor specific preferences.

This research will benefit the profession of health care chaplaincy in this ever changing health care landscape in the United States. One of the benefits of this study is I will analyze the role using a time-tested, research-based method, namely DACUM (Developing A Curriculum), which has been used worldwide as a foundation for the development of curriculum, organizational development, and occupational profiles.

Though this study is focusing on health care chaplains in the New York Tri-State area, if the process and final profile are deemed beneficial to the profession, other geographic regions may opt to have a profile completed on health care chaplains. This will help to build a complete picture of health care chaplaincy.

Furthermore, since health care chaplains are certified, based on Denominational (religious) affiliation, the findings of this study could impact the certification roadmaps published for chaplains by the major certifying organizations: the Association of Professional Chaplains (APC), the National Association of Catholic Chaplains (NACC), the National Association of Jewish Chaplains (NAJC), and the Association of Clinical Pastoral Education (ACPE).

Methodology: A mixed methods case study approach, with an emphasis on qualitative methods, has been selected for this study. The reason is that the selected approach is well suited for exploring unique cases that have little or no research associated with them such as the case with the role of health care chaplain (Creswell & Plano Clark, 2011; Fetters, Curry, & Creswell, 2013).

I examined one cross-section of chaplains in the metropolitan New York area, affiliated with one organization, The HealthCare Chaplaincy Network, which currently collaborates with a number of health care institutions in the New York City area and several cities across the United States. I wanted to see if the DACUM process, taught at Eastern Kentucky University, can be used to generate an accurate occupational profile of the profession. To ensure greater accuracy two panels worked to reach consensus on a profile that represents what health care chaplains do and need to know to function successfully in health care settings today. In addition, I want to assess if a panel of curriculum experts and a panel of Clinical Pastoral Supervisors who train chaplains can use the profile to develop curriculum, and deliver training for future learning interventions. Finally, I will assemble a panel of chaplains from the five major regions of the United States to evaluate the final profile from the first four panels applicability to chaplains in other geographic regions.

The research will generate some basic quantitative statistics, in addition to qualitative data primarily from DACUM focus groups (panels), semi-structured interviews, and surveys. For the purpose of this study, the term focus group and panel will be synonymous.

For this study, five panels will be convened and considered as data sources. These five panels are (1) an initial DACUM panel, (2) a validation DACUM panel, (3) a panel of CPE Supervisors (trainers), (4) a panel whose focus is curriculum development and (5) a panel of chaplains from other regions of the United States. The members of the initial panel were be purposefully selected using criterion sampling (Patton, 2002). The methods of data collection for this panel were (1) surveys, (2) interviews, (3) the DACUM panel, and (4) a prioritization coding exercise performed during the first three panels. Two primary types of surveys were used. The first survey was a demographic survey developed in such a manner to gather data about each participant's race, gender, experience, and religious affiliation. The second survey was administered at the end of each day's session. The panels were asked to complete a short pencil and paper survey to assess the most satisfactory, successful, and challenging aspects of the DACUM process.

Panelists were asked to participate in interviews after their panel convened to document their satisfaction, successes, and challenges and to validate my analysis of their comments during the panel. All interviews were digitally recorded, transcribed, and thematically coded. These interviews were semi-structured following an interview guide similar to the one used by Barrows (1993) in his sociological study of hospital chaplains.

The initial panel went through a three-day framework where they collectively developed a DACUM profile in the form of a storyboard that detailed the duties and tasks performed by health care chaplains. In addition, as the panel worked through the process they listed the requisite knowledge, skills, traits and tools leveraged by expert health care chaplains. One of several prioritizing exercises practiced by facilitators trained at EKU on the final day of the panel has the initial panel participants apply colored dots to those tasks, knowledge, and skills that they perceive as being new worker or veteran worker training needs. Green dots are applied for new worker training needs and yellow dots are applied for veteran worker training needs. Part of the coding exercise included applying red dots to tasks they individually deemed critical to the profile, and blue dots to tasks they individually deemed were frequently done by health care chaplains. Participants were also asked to apply orange dots to tasks they deemed difficult to

learn. This panel was also asked to apply silver stars to tasks they felt they received inadequate training on during CPE.

The validation panel of chaplains reviewed the initial panel's profile, as well as their lists of knowledge, skills, traits, and tools. They were asked to suggest changes, additions and deletions. In addition, they were asked to go through the prioritization exercise for training needs and learning difficulty. This panel was also asked to apply red stars to tasks they felt they received inadequate training on during CPE.

The panel of CPE Supervisors, who educate chaplains, met to review the final products provided by the initial panel and validation panel. A full review of the profile, lists and prioritizations was explained. The panel was then asked whether the final products meet their expectations and needs as trainers. They were asked to identify, from their perception, what are the strengths and weaknesses of the profile. Finally, they will be asked from their position as an educator, which components of the final products will be the easiest and the most difficult to implement in a training intervention, and what challenges do they anticipate in implementing this data into their training routines. They were asked to go through the Prioritization Coding exercise and apply dots to those tasks that they consider difficult to teach and easy to teach.

The fourth panel, the curriculum development panel, will be made up of experts from the field of curriculum design and development. The purpose of this panel will be to evaluate the final profile, passed to them from the initial and validation panels, and the CPE Supervisor panel. This panel will be conducted as a virtual focus group several weeks after the profile is digitized and distributed to the members of this panel. They will be asked to comment and provide editorial guidance on whether the profile will be a viable source for the design and development of future curriculum offerings for health care chaplains. They will be asked from their position as a curriculum developer, which components of the final products will be the easiest and the most difficult to implement in a future curriculum, as well as what challenges do they anticipate in implementing this data into new curriculum.

The fifth panel will be made up of chaplains from diverse areas of the United States. Preferably I will try to identify health care chaplains who meet the same criteria established for the initial and validation panels from the rosters of the APC, ACPE, NAJC, and NACC. The goal is to select 1-2 chaplains from each of 5 geographic regions of the United States. The five regions are Northeast (Non-NYC), mid-west, west, south-west, and south-east. This group will be contacted by email for willingness to participate. If they agree, they will be emailed, the Informed Consent to digitally sign, the link to the Demographic survey and the final profile from the first four panels and asked to respond to the following questions: does this profile accurately reflect what you do in your role as a health care chaplain? If it does, please identify elements that are an accurate reflection. If it does not, please identify those elements that are not an accurate representation or gaps that you have identified.

Key for Occupational (Storyboard) Profile:

1. Column 2 (Orange color): Defines the 9 Duties identified by the panels. A Duty is a general area of competence that successful workers in the occupation must demonstrate or perform on an ongoing basis.

2. Each corresponding row (Violet and Yellow) is a duty band made up of tasks. A Task is a work activity that has a definite beginning and ending, is observable, consists of two or more definite steps, and leads to a product, service, or decision.
3. Violet tasks are those identified by the initial panel
4. Yellow duties and tasks are those that were modified/moved by the validation panel
5. Each task has a key in the bottom of the box, such as C=3,F=0,N=2,V5.This key identifies how many participants from the initial and validation panel during the coding exercise placed a red, blue, green, or yellow dot on it. This key indicates Critical to their role, Frequently done by a chaplain, New Workers need training on this task, or Veteran Workers need training on this task.

Color Key used for Prioritization Coding Exercise

These were also identified as part of the Knowledge, Skills, Traits and Tools (KSTT) exercise:

1. Red –Critical tasks (Also identified with C=)
2. Blue –Frequently done tasks (Also identified with F=)
3. Green –Knowledge, Skills and Tasks identified as New Worker Training Needs (Also identified with NW or N=)
4. Yellow - Knowledge, Skills and Tasks identified as Veteran Worker Training Needs (Also identified with VW or V=)
5. Orange – Tasks identified by the initial and validation panels as difficult to learn
6. Silver –Tasks identified by the initial and validation panels as having received inadequate preparation during CPE
7. White –Tasks identified by Supervisors as easy to teach
8. Grey –Tasks identified by Supervisors as difficult to teach

The following are the two job descriptions created by the initial and validation panels. This is the first exercise performed in a DACUM session.

Job Description 1 Initial Panel:

Professional healthcare chaplains, grounded in faith, enable people to access their spiritual/emotional resources in order to provide hope, comfort, and healing. Chaplains achieve this by doing a spiritual assessment, developing and implementing a care plan, measuring outcomes and providing documentation.

Job Description 2 Validation Panel:

Professional healthcare chaplains help create a sacred space for people of any or no faiths and cultural beliefs in stressful, life-changing or transitional moments to find meaning, hope, connection, and comfort by enabling them to identify and draw upon their own sources of inner strength.

DACUM Profile: Health Care Chaplain							Development History:			Initial: 11/17-19/14 Validation:11/20/14 CPE Supervisor:11/21/14 Curriculum Dev.: TBD
A	Conduct Chaplaincy Encounters	Establish chaplain/patient/family staff connection C= 4;F=1 ;N=0 ; V=3 ;	Conduct Spiritual Assessments C= 5;F=3 ;N=1 ; V=3 ;	Develop Care Plan C= 2;F=1 ;N=0 ; V=1 ;	Conduct Chaplaincy intervention C= 5;F=5 ;N=2 ; V=0 ;	Measure Outcomes C= 0;F=0 ;N=1 ; V=2 ;	Identify additional needs C= 1;F=0 ;N=0 ; V=0 ;	Document Visit C= 5;F=7 ;N=2 ; V=1 ;		KEY: C=Criticality F=Frequency N=New Worker V=Veteran Worker
B	Provide Education	Train community clergy and volunteers C= 0;F=0 ;N=0 ; V=0;	Orient new staff to chaplaincy C= 2;F=0 ;N=1 ; V=1 ;	Provide ongoing spiritual/religious staff education C= 1;F=1 ;N=1 ; V=2 ;	Conduct didactic and inservice C= 0;F=0 ;N=0 ; V=1 ;	Mentor CPE and other students C= 3;F=2 ;N=0 ; V=0 ;	Educate/train chaplaincy staff C= 0;F=1 ;N=0 ; V=0;	Offer general community education C= 0;F=0 ;N=0 ; V=0 ;		KEY: Violet tasks=Initial Yellow duties and tasks=Validation Changes
C	Provide Institutional Leadership	Conceptualize vision for chaplaincy care that supports and enhances the institution C= 1;F=1 ;N=0 ; V=2 ;	Serve as a resource and point person for moral, ethical and spiritual issues C= 2;F=1 ;N=0 ; V=0 ;	Identify opportunities for system wide improvement for healing and justice C= 0;F=0 ;N=0 ; V=0;	Conduct services C= 2;F=3 ;N=0 ; V=1 ;	Provide chaplaincy presence at institutional events C= 0;F=2 ;N=1 ; V=0 ;	Lead/facilitate groups C= 0;F=0 ;N=0 ; V=1 ;	Conduct crisis intervention and debriefing session C= 0;F=0 ;N=2 ; V=1 ;		
D	Promote Chaplaincy Care	Ensure each chaplain's intergration into the department and wider institution C= 0;F=1 ;N=1 ; V=1 ;	Identify and maintain relationships with "chaplaincy champions" C= 2;F=2 ;N=0 ; V=1 ;	Stay abreast of internal and external trends empacting the role of chaplains C= 1;F= ;N=0 ; V=0;	Market chaplaincy through multiple media C= 1;F=1 ;N=0 ; V=0;					
E	Administration	Develop, maintain and review proper policies and procedures C= 1;F=1 ;N=0 ; V=1 ;	Ensure timely and appropriate delivery of spiritual care C= 2;F=4 ;N=0 ; V=1 ;	Ensure chaplain understands responsibility in hospital structure C= 0;F=0 ;N=1 ; V=2 ;	Collaborate and integrate with hospital management team C= 1;F=4 ;N=0 ; V=1 ;	Measuring and documenting the impact of chaplaincy care C= 1;F=4 ;N=0 ; V=1 ;	Conduct annual performance reviews C= 0;F=0 ;N=0 ; V=0;	Create and negotiate department budget C= 0;F=0 ;N=1 ; V=0;	Design care plan for electronic medical records C= 0;F=1 ;N=0 ; V=1;	Recruit community clergy and volunteers C= 0;F=1 ;N=0 ; V=0;
		Coordinate community clergy and volunteers C= 1;F=0 ;N=0 ; V=0;	Participate in the interviewing of new staff C= 0;F=0 ;N=0 ; V=0;	Initiate and develop Performance improvement and Quality improvement C= 1;F=2 ;N=1 ; V=1;	Prepare for and demonstrate with/for internal and external regulatory bodies C= 0;F=0 ;N=0 ; V=0;					
F	Facilitate Connections	Promote collaboration among patients, staff and family C= 2;F=0 ;N=0 ; V=1;	Help patients and family navigate the healthcare system and beyond C= 2;F=2 ;N=1 ; V=1;	Facilitate relationships with religious and community groups C= 0;F=0 ;N=0 ; V=1;	Establish collegial relationships within and beyond the department C= 0;F=0 ;N=0 ; V=0;					
G	Professional Development and Self Care	Attend workshops and seminars and retreats C= 1;F=0 ;N=0 ; V=0;	Network with peers C= 0;F=0 ;N=0 ; V=0;	Read professional literature C= 0;F=1 ;N=0 ; V=0;	Participate in chaplaincy certifying agencies and boards C= 0;F=0 ;N=0 ; V=0;	Maintain certification, endorsements, and ethical standing C= 1;F=0 ;N=0 ; V=0;	Practice self care C= 3;F=0 ;N=1 ; V=1;	Contribute to the field through research, teaching, and publication C= 1;F=0 ;N=1 ; V=4;	Participate in social media platforms C= 0;F=0 ;N=0 ; V=0;	Development of ancillary skills such as language, computer, etc. C= 0;F=0 ;N=0 ; V=1;
H	Team Participation	Model teamwork within the department C= 2;F=0 ;N=0 ; V=0;	Interact with interdisciplinary team C= 4;F=3 ;N=2 ; V=2;	Serve on specialized treatment teams (such as palliative care) C= 1;F=2 ;N=1 ; V=1;	Serve on system wide committee such as ethics and IRB's C= 1;F=0 ;N=2 ; V=0;	Engage in family conferences, ethics, consults, etc C= 0;F=1 ;N=1 ; V=1;	Participate in on-call rotation C= 1;F=0 ;N=0 ; V=0;	Foster a vision of community within the system rather than "us vs them" C= 0;F=0 ;N=1 ; V=0;	Support chaplaincy staff C= 0;F=2 ;N=0 ; V=0;	
I	Triage Visits	Identify referrals C= 0;F=1 ;N=0 ; V=0;	Prioritize Referrals C= 3;F=2 ;N=0 ; V=0;	Conduct referred visits C= 4;F=4 ;N=0 ; V=0;	Conduct unreferred visits C= 1;F=2 ;N=1 ; V=0;					

TOP TASKS IN 8 CATEGORIES AS RATED BY THREE PANELS-1

CRITICAL TASKS		FREQUENTLY DONE TASKS		TASKS WHERE NEW WORKERS NEED TRAINING		TASKS WHERE VET WORKERS NEED TRAINING	
Conduct Spiritual Assessments	8	Document Visits	7	Conduct Chaplaincy Interventions	2	Contribute to the field through research, teaching, and publication	4
Conduct Chaplaincy Interventions	5	Conduct Chaplaincy Interventions	5	Document Visits	2	Establish chaplain/patient/family staff Connection	3
Document Visits	4	Ensure timely and appropriate delivery of spiritual care	5	Conduct crisis intervention and debriefing session	2	Conduct Spiritual Assessments	3
Establish chaplain/patient/family staff Connection	4	Collaborate and integrate with hospital management team	4	Interact with interdisciplinary team(s)	2	Measure Outcomes	2
Interact with interdisciplinary team(s)	4	Measuring and documenting the impact of chaplaincy care	4	Serve on system-wide committees, such as ethics and IRBs	2	Provide ongoing spiritual/religious staff education	2
Conduct referred visits	4	Conduct referred visits	4			Conceptualize vision for chaplaincy care that supports and enhances the institution	2
Mentor CPE and other students	3	Conduct Spiritual Assessments	3			Ensure chaplain understands responsibility in hospital structure	2
Practice self-care	3	Conduct services	3			Interact with interdisciplinary team(s)	2
Prioritize referrals	3	Interact with interdisciplinary team(s)	3				
Develop Care Plan	2	Mentor CPE and other students	2				
Orient new staff to chaplaincy	2	Provide chaplaincy presence at institutional events	2				
Serve as a resource and point person for moral, ethical, and spiritual issues	2	Identify and maintain relationships with "chaplaincy champions"	2				
Conduct services	1	Initiate and develop Performance Improvement and Quality Improvement	2				
Identify and maintain relationships with "chaplaincy champions"	1	Help patients/family navigate the healthcare system and beyond	2				
Ensure timely and appropriate delivery of spiritual care	1	Serve on specialized treatment teams (such as palliative care)	2				
Promote collaboration among patient staff and family	1	Support chaplaincy staff	2				
Help patients/family navigate the healthcare system and beyond	1	Prioritize referrals	2				
Model teamwork within the deparment	1	Conduct unreferred visits	2				

TOP TASKS IN 8 CATEGORIES AS RATED BY THREE PANELS-2

TASKS MOST DIFFICULT TO LEARN		TASKS NOT PREPARED FOR BY CPE		TASKS EASIEST TO TEACH		TASKS MOST DIFFICULT TO TEACH	
Conduct Spiritual Assessments	8	Measure Outcomes	6	Conduct Chaplaincy Interventions	3	Measure Outcomes	4
Measure Outcomes	6	Conduct Spiritual Assessments	5	Establish chaplain/patient/family staff Connection	2	Identify opportunities for system wide improvement for healing and justice	3
Develop Care Plan	5	Conduct annual performance reviews	5	Practice self-care	2	Create and negotiate department budget	3
Document Visits	5	Create and negotiate department budget	5	Conduct unreferred visits	2	Contribute to the field through research, teaching, and publication	3
Interact with interdisciplinary team(s)	5	Initiate and develop Performance Improvement and Quality Improvement	5	Identify Additional Needs	1	Develop Care Plan	2
Conceptualize vision for chaplaincy care that supports and enhances the institution	4	Conduct crisis intervention and debriefing session	4	Document Visits	1	Measuring and documenting the impact of chaplaincy care	2
Practice self-care	4	Document Visits	3	Conduct services	1	Document Visits	1
Conduct Chaplaincy Interventions	3	Develop, maintain and review policies and procedures	3	Provide chaplaincy presence at institutional events	1	Educate/train chaplaincy staff	1
Design care plan for electronic medical records	3	Develop Care Plan	2	Ensure each chaplain's integration into department and wider institution	1	Develop, maintain and review policies and procedures	1
Contribute to the field through research, teaching, and publication	3	Provide ongoing spiritual/religious staff education	2	Ensure timely and appropriate delivery of spiritual care	1	Conduct annual performance reviews	1
Identify Additional Needs	2	Conduct services	2	Recruit Community Clergy and volunteers	1	Design care plan for electronic medical records	1
	2	Identify and maintain relationships with "chaplaincy champions"	2	Facilitate relationships with religious and community groups	1	Initiate and develop Performance Improvement and Quality Improvement	1
Conduct crisis intervention and debriefing session	2	Interact with interdisciplinary team(s)	2	Maintain certification, endorsement and ethical standing	1	Interact with interdisciplinary team(s)	1
Stay abreast of internal and external trends impacting the role of chaplains	2	Serve on system-wide committees, such as ethics and IRBs	2	Participate in on-call rotation	1		
Model teamwork within the deparment	2			Prioritize referrals	1		
Serve on specialized treatment teams (such as palliative care)	2			Conduct referred visits	1		

Occupation ANALYSIS

Knowledge, Skills, Traits and Tools Summary

		KSTT Exercise with Dots
NW Training Needed	VW Training Needed	Knowledge(33)
3	1	Hospital chain of command
		Knowledge of differences
2		General understanding of other healthcare roles
2		Knowledge of other team members roles
1		Knowledge of other cultural traditions
	1	Bereavement theory
3		Medical terms
3	1	Knowledge of self
1	1	Deep knowledge of own faith traditions
1	2	Hospital policies and procedures
2		Boundaries
		Ethics
1		HIPPA
2		Theological grounding
		Stages of human development
3	1	Knowledge of hospital/institutional culture
		Substance abuse
1		What your job is NOT
1		Working knowledge of other faith traditions-protestant traditions
1		Knowledge of Gods messengers (Knowledge of sacred texts)
		Community organizations
	1	Who can get things done
		Stages of faith development
1		Basic computer applications
		Identify psychiatric issues to properly manage patients
1		Triangulation
		Knowledge of psychological systems
		Transference/counter transference
		End of life care/advanced directives
		Disaster training
		Palliative care principles
		Knowledge of religious practices
1		Religious protocols/practices

		KSTT Exercise with Dots
NW Training Needed	VW Training Needed	Skills(27)
1		Active listening
1	1	How to communicate in a crisis situation
1		Communication skills
2		Develop relationships
	1	Think quickly on your feet
	3	Leadership
		Know when to refer
		Politicking inside institution (diplomacy)
4	4	Self-care
	2	Non-sectarian prayer
1		Work-life balance
	1	Computer skills
1	1	Conflict management
		Mediation
1		Articulation of faith traditions
		Leading ecumenical worship service
		Managing crisis situations to diffuse
1	1	Transferable skills from previous jobs
		Public speaking
		Defining boundaries
		Time management
	1	Organization
1	1	Team work
	1	Research literacy
	1	Multitasking
		Presentation
	1	Teaching

KSTT Exercise without Dots
Traits (40)
Intuitive
Resilience
Patience
Strong stomach
Joy
Sense of humor
Compromise
Flexibility
Assertiveness
Self confidence
Persistence
Vulnerability
Pastoral idenity/authority
Faithfulness
Hopeful
Reliability
Positive outlook
Personal spiritual life
Speak the truth
Empathy
Compassion
Mindfulness
Self control
Humility
Self-motivating
Independent work
Calm
Open--minded
Introspection
Non-judgmental
Kind
Engaging
Approachable
Curiosity
Grounded in own theology
Humorous
Create safe space
Enables others to experience hope and meaning
Understands relationships and how they impact the patient
Believes work is sacred and critical to patients health

KSTT Exercise without DOTS
Tools(24)
Referral list
Phone
Computer
Internet
Outlook
Patient chart
Religious articles
Prayer card
Calling card
Business card
Referral card
Tablet
Hand sanitizer
Xerox
Printer
Comfortable shoes
Pager
Smart phone
Instant messenger
Google
ID badge
Watch
Skype
Professional attire

APPENDIX I:

Left-side and Right-side of Panel 1 DACUM Storyboard

Figure I1. Left-side of Panel 1 Storyboard Showing Nine Duties and First Four Tasks for Each Duty Band

Figure I2. Right-side of Panel 1 Storyboard Showing the Remaining Tasks for Each Duty Band

APPENDIX J:

Left-side and Right-side of Panel 2 DACUM Storyboard

Figure J1. Left-side of Panel 2 Storyboard Showing Nine Duties and First Five Tasks for Each Duty Band

Figure J2. Right-side of Panel 2 Storyboard Showing the Remaining Tasks for Each Duty Band

APPENDIX K:

Table K1-Table K12: Matrices Showing Each Research Question Mapped to Sampling Methods, Collection and Analysis Methods.

Table K1

Matrix for the DACUM Analysis of Health Care Chaplains - Research Question 1

Research Question	Why do I need to know this?	Sampling decisions: Data Sources	Data collection Methods	Data Analysis
1	To understand and establish a baseline profile for the role of health care chaplain.	9 Chaplains from a cross-section of chaplains based on race, gender, experience, and religious affiliation	Demographic survey	Demographic frequencies
			Telephone interviews – post panel	Code data from interview transcripts
			3 Day Initial DACUM panel	Code daily profile notes and transcripts for themes Member checking for valid interpretation
			Observational journal memos	Code observational notes for themes
			End of day and End of Session Surveys	Survey means, frequencies and themes based on demographics

Table K2

Matrix for the DACUM Analysis of Health Care Chaplains - Research Question 1a

Research Question	Why do I need to know this?	Sampling decisions: Data Sources	Data collection Methods	Data Analysis
1a	To understand and establish a baseline of knowledge, skill, and tasks requiring training	9 Chaplains from a cross-section of chaplains based on race, gender, experience, and religious affiliation	3 Day Initial DACUM panel	Code observational notes and transcripts for themes Member checking for valid interpretation
			Prioritization dotting exercise	Descriptive statistics and frequencies of New Worker Training and Veteran Worker Training; Comparative Analysis of dotting exercise based on race, gender, experience and religious affiliation

Table K3

Matrix for the DACUM Analysis of Health Care Chaplains - Research Question 1bi

Research Question	Why do I need to know this?	Sampling decisions: Data Sources	Data collection Methods	Data Analysis
1 b and 1bi	To understand if there are any differences based on demographics with process satisfaction, success, and challenges.	9 Chaplains from a cross-section of chaplains based on race, gender, experience, and religious affiliation	Demographic survey	Demographic frequencies
			Observational journal memos; Post panel interviews	Coding and thematic analysis of memos and interviews
			End of day and End of Session Surveys	Survey data comments and means

Table K4

Matrix for the DACUM Analysis of Health Care Chaplains - Research Question 2

Research Question	Why do I need to know this?	Sampling decisions: Data Sources	Data collection Methods	Data Analysis
2	To understand and validate the profile for the role of health care chaplain established by the initial panel.	6 Chaplains from a cross-section of chaplains based on race, gender, experience, and religious affiliation.	Demographic survey	Demographic frequencies
			Telephone interviews including post panel	Code data from interview transcripts
			Validation DACUM panel	Code daily profile notes and transcripts for themes Member checking for valid interpretation
			Observational journal memos	Code observational notes for themes
			End of day and End of Session Surveys	Survey means, frequencies and themes based on demographics

Table K5

Matrix for the DACUM Analysis of Health Care Chaplains - Research Question 2a

Research Question	Why do I need to know this?	Sampling decisions: Data Sources	Data collection Methods	Data Analysis
2a	To understand and validate the knowledge, skill, and tasks requiring training.	6 Chaplains from a cross-section of chaplains based on race, gender, experience, and religious affiliation.	Validation DACUM Panel	Code daily profile notes and transcripts for themes Member checking for valid interpretation
			Prioritization dotting exercise	Descriptive statistics and frequencies of New Worker Training and Veteran Worker Training; Comparative Analysis of dotting exercise based on race, gender, experience and religious affiliation

Table K6

Matrix for the DACUM Analysis of Health Care Chaplains - Research Questions 2b and 2bi

Research Question	Why do I need to know this?	Sampling decisions: Data Sources	Data collection Methods	Data Analysis
2b	To understand if the DACUM process works for analyzing the role of health care chaplain.	6 Chaplains from a cross-section of chaplains based on race, gender, experience, and religious affiliation	Observational journal memos;	Code observational notes and reflections
			Post panel interviews	Coding and thematic analysis of memos and interviews
			End of day and End of Session Surveys	Survey data comments and means
2bi	To understand if there are any differences based on demographics with process satisfaction, success, and challenges.	6 Chaplains from a cross-section of chaplains based on race, gender, experience, and religious affiliation.	Demographic survey	Demographic frequencies
			Observational journal memos; Post panel interviews	Coding and thematic analysis of memos and interviews
			End of day and End of Session Surveys	Survey data comments and means

Table K7

Matrix for the DACUM Analysis of Health Care Chaplains - Research Question 3

Research Question	Why do I need to know this?	Sampling decisions: Data Sources	Data collection Methods	Data Analysis
3	To understand if the DACUM panel process produces results that can be used by CPE supervisors who train chaplains.	4 CPE supervisors from a cross-section of health care institutions	Demographic survey	Demographic frequencies
			Telephone interviews including post panel	Code data from interview transcripts
			CPE supervisor DACUM panel	Code daily profile notes and transcripts for themes Member checking for valid interpretation
			Observational journal memos	Code observational notes for themes
			Prioritization dotting exercise review	Descriptive statistics and frequencies analyzed
			End of day and End of Session Surveys	Survey means, frequencies and themes based on demographics

Table K8

Matrix for the DACUM Analysis of Health Care Chaplains - Research Question 3a

Research Question	Why do I need to know this?	Sampling decisions: Data Sources	Data collection Methods	Data Analysis
3a	To understand from the CPE supervisor's perspective the strengths and weaknesses of the final profile. To understand what were the hits and the misses of the process and the profile.	4 CPE supervisors from a cross-section of health care institutions	Demographic survey	Demographic frequencies
			Telephone interviews – post panel	Code data from interview transcripts
			CPE supervisor DACUM panel	Code daily profile notes and transcripts for themes Member checking for valid interpretation
			Prioritization dotting exercise review	Descriptive statistics and frequencies analyzed
			Observational journal memos	Code observational notes for themes
			End of day and End of Session Surveys	Survey means, frequencies and themes based on demographics

Table K9

Matrix for the DACUM Analysis of Health Care Chaplains - Research Question 3b

Research Question	Why do I need to know this?	Sampling decisions: Data Sources	Data collection Methods	Data Analysis
3b	To understand from the CPE supervisor's perspective which parts of the final profile are going to be easy and difficult to implement in a training intervention.	4 CPE supervisors from a cross-section of health care institutions	Demographic survey	Demographic frequencies
			Telephone interviews including post panel	Code data from interview transcripts
			CPE supervisor DACUM panel	Code daily profile notes and transcripts for themes Member checking for valid interpretation
			Prioritization dotting exercise review	Descriptive statistics and frequencies analyzed
			End of day and End of Session Surveys	Survey means, frequencies and themes based on demographics

Table K10

Matrix for the DACUM Analysis of Health Care Chaplains - Research Question 3bi

Research Question	Why do I need to know this?	Sampling decisions: Data Sources	Data collection Methods	Data Analysis
3bi	To understand from the CPE supervisor's perspective the challenges in leveraging the final profile into a training intervention. To understand how the delivery of Clinical Pastoral Education could be impacted.	4 CPE supervisors from a cross-section of health care institutions	Demographic survey Telephone interviews including post panel CPE supervisor DACUM panel Prioritization dotting exercise review End of day and End of Session Surveys	Demographic frequencies Code data from interview transcripts Code daily profile notes and transcripts for themes Member checking for valid interpretation Descriptive statistics and frequencies analyzed Survey means, frequencies and themes based on demographics

Table K11

Matrix for the DACUM Analysis of Health Care Chaplains - Research Questions 4 and 4a

Research Question	Why do I need to know this?	Sampling decisions: Data Sources	Data collection: Methods	Data Analysis
4	To understand if the DACUM panel process produces results that can be used by curriculum developers.	3 curriculum developers or those with experience in the development of curriculum for chaplains	Demographic survey 2 hour web conference-based panel with optional: 1:1 telephone interviews	Descriptive statistics on years of experience Code panel transcripts for themes Member checking for validating my interpretation
4a	To understand from a curriculum developer's perspective the strengths and weaknesses of the final profile. To understand what were the hits and the misses of the process and the profile.	3 curriculum developers or those with experience in the development of curriculum for chaplains	Demographic survey 2 hour web conference-based panel with optional: 1:1 telephone interviews	Descriptive statistics on years of experience Code panel transcripts for themes Member checking for validating my interpretation

Table K12

Matrix for the DACUM Analysis of Health Care Chaplains - Research Questions 4b and 4bi

Research Question	Why do I need to know this?	Sampling decisions: Data Sources	Data collection Methods	Data Analysis
4b	To understand from a curriculum developer's perspective which parts of the final profile are going to be easy and difficult to implement in a curriculum.	3 curriculum developers or those with experience in the development of curriculum for chaplains	Demographic survey 2 hour web conference-based panel with optional: 1:1 telephone interviews	Descriptive statistics on years of experience Code panel transcripts for themes Member checking for validating my interpretation
4bi	To understand from a curriculum developer's perspective the challenges in leveraging the final profile into a curriculum. To understand how Clinical Pastoral Education curriculum can be impacted.	3 curriculum developers or those with experience in the development of curriculum for chaplains	Demographic survey 2 hour web conference-based panel with optional: 1:1 telephone interviews	Descriptive statistics on years of experience Code panel transcripts for themes Member checking for validating my interpretation