

Beyond Clinical Specificity: A Model of Chaplaincy and Clinical Spiritual Care within
the Shifting Paradigm of Population Health

by

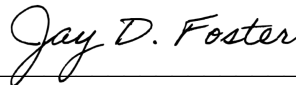
Adam Walter Ridenhour

Date: December 6, 2022

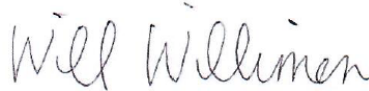
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Thesis submitted in partial fulfillment of
the requirements for the degree of Doctor of Ministry
in the Divinity School of Duke University

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ABSTRACT

Beyond Clinical Specificity: A Model of Chaplaincy and Clinical Spiritual Care within
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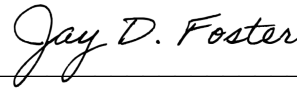
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Abstract

This thesis will examine hospital chaplaincy and its role within the changing paradigm of population health by addressing the question of what chaplaincy looks like beyond the walls of the hospital. The thesis will include several moves that account for the development of the profession and possible areas of growth in dialogue with public health and behavioral health. The first move is historical. This section will cover the development of chaplaincy at Atrium Health Wake Forest Baptist and its relationship to counseling, community engagement, and accrediting bodies. It will also discuss the formation of FaithHealth as both a divisional identity as part of Atrium Health Wake Forest Baptist and a distinct department of community engagement. The second move will be to present the role of chaplain manager within the division of FaithHealth of Atrium Health Wake Forest Baptist and its pioneering work of integrating chaplaincy, community engagement, and licensed counseling. The third move will describe the function of chaplain managers during the coronavirus pandemic and the structure that allowed the model to adapt to a changing landscape. The final move will evaluate the role of chaplain managers from the individuals that assume these roles and leaders within the medical system and provide a snapshot into future possibilities for this role and innovative ministry opportunities.

The purpose of this work is threefold: 1) to provide a model for integrating spiritual care, behavioral health and population health into the role of chaplain manager; 2) to advocate for the profession's continued expansion by adapting chaplaincy's skillsets in community health; 3) to begin a conversation about modifying educational and professional bodies to best prepare graduates and professionals for the changing

landscape of healthcare. Such a model could provide clearer vocational pathways for dual degree divinity school programs and forge new partnerships between public health and divinity schools. Furthermore, given the reinstated associational connection between pastoral counseling and clinical pastoral education, this model of integration could create new associational paths to certification.¹ The connection between pastoral counseling and chaplaincy that thrived before managed care will be revisited as it shows different, yet complementary, fruits of deeply rooted spiritual care.

¹ The line of division between chaplaincy and pastoral counseling was much thinner before the rise of managed care and state counseling licensure in the latter part of the twentieth century. The merger between the American Association of Pastoral Counselors (AAPC) and the Association for Clinical Pastoral Education (ACPE) and the halted merger between these entities and the Association of Professional Chaplains (APC), offers the possibility reengaging these professional disciplines in conversation. Per an email to Board Certified Chaplains from APC on August 26, 2022, conversations have of a merger between ACPE and APC have resumed.

Dedication

To my teachers, I am grateful for your wisdom and guidance. To my colleagues, I am grateful to serve and learn with you. To my family, I am grateful for your enduring love and unwavering support. Thank you all.

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Introduction

In the summer of 2008, I read Jim Wooten's *We are All the Same* for freshmen orientation at a small liberal arts college in North Carolina. The book is about the human dimension of virtue, resilience, and community in South Africa amid the twentieth century AIDS crisis. While the play on the book's title shifts and broadens throughout the book, the story is one that focuses on commonality and congruence in the human story of tragedy and resilience. What I have come to realize about my own journey of education, vocational discernment and the practice of ministry is the centrality of likeness and difference.

For instance, much is written in philosophy and theology about human nature, the human condition, and the evaluation of humanity based on set values and virtues for one's self, one's neighbor, and, for some, a deity. But, it also describes the individualized experience of meditation, prayer, and individuals' unique spiritual journeys. In the social science disciplines, theories of human development, the formation and developmental stages of various mental illnesses, and various treatment models follow a prescribed theorem of collective human experience. Yet, the unique experiences of trauma, chemical imbalances, ethnicity, sexual orientation, gender identity, socio-economic statuses, cultural bias, familial expectations and a plethora of other unique traits complicates the assumptions and appropriateness of various theoretical perspectives.

Much of my experience of healthcare follows a similar trajectory. There are key measures of health that are universal; blood pressure range, body temperature, blood types and a host of other "normal" features of being human that can measure health and

wellness relatively well. But other factors, such as access to care, affordability of healthcare, availability of healthy foods and clean drinking water, and mental health in feeling safe and supported are not congruent for all people. No, we're not all the same. While the diversity and complexity of humanity is beautiful, its beauty does not equate to equity. We are not the same.

At the writing of this thesis, the United States is experiencing the Supreme Court's overturning of Roe vs. Wade, continuing COVID-19 pandemic, global inflation, mass shooting incidents in schools, faith communities and hospitals, political division and skepticism of institutions, and a new chapter of devaluing black bodies. There is a diaspora of clergypersons leaving the church, creating a void nearly as big as nursing profession whose aging workforce is retiring without nursing students to take their places. In my area of the North Carolina, the waitlist to see a mental health provider is an average of three months.

These are community problems that will take a community effort to mitigate. None of the issues I have mentioned thus far happen in a vacuum; each represents an issue that is constructed within webs of systems that affect the individual and communal alike. Take, for instance, cardiovascular health. While diet and exercise certainly impact cardiac health, so does stress, the availability of healthy foods, regular physicals with a primary care physician and routine visits to the dentist, and the availability and influence of tobacco and tobacco-related products on individuals and local communities.

This thesis is about spiritual care in the ever-evolving contexts of United States medical systems. It is a challenge to broaden the perspective of spiritual care beyond the silo-ed roles of chaplaincy, counseling and community engagement to care for the health

of a community within and beyond the walls of the medical center. It is an invitation to counter webs of human complexity with webs of trusting relationships; it is stepping moving beyond a role or function within a profession to being a contributor in networks of support fostering healing and wholeness within a community. To borrow a term from Gary Gunderson, the founder of FaithHealth and the vice president of the division of Faith and Health and Atrium Health Wake Forest Baptist, the role of ministers in this space is to help communities engage in reverse epidemiology by identifying assets of life within communities rather than areas of death.¹

This integrated role of chaplaincy, counseling and community engagement at Atrium Health Wake Forest Baptist lives in the community hospital role of chaplain managers. As integrated practitioners, chaplain managers offer a span of ministry that encompasses traditional chaplaincy, counseling and community engagement in one holistic role. Furthermore, this model offers space to collaborate with the web of trusting relationships that supports individuals as they leave the medical center. Traditional chaplaincy can now extend beyond a patient's discharge to the healing structures of one's community, which includes, but is not limited to, one's faith community. This transition will be revisited throughout this thesis.

The Why

Why focus a thesis for a Doctor of Ministry degree on healthcare leadership, population health, and managerial principles? My "why" is that according to my faith tradition, loving God means having a responsibility to care for my neighbor. Jon Sobrino

¹ See Gary Gunderson and Larry Pray, *Leading Causes of Life: Five Fundamentals to Change the Way You Live Your Life* (Nashville: Abingdon Press, 2009).

writes, “Jesus sheds light on God in proclaiming that love of God and love of neighbor are inseparable, not as something arbitrary, but because this is how God is and this is how we correspond to God. Jesus also proclaims...that by loving our neighbor we prove our love for God.”²

The FaithHealth chaplaincy model affords me the opportunity to care for my neighbor through the specialized ministry of chaplaincy and counseling, but it also provides avenues to partner with various community entities in addressing complex community problems. I am an advocate for this role because I have seen too many neighbors fall through the cracks of helping agencies and this model intentionally walks alongside those whose cases are too complex for a one-size-fits-all approach. Despite the challenges produced by this role, I serve as a chaplain manager because I have seen how partnership, collaboration and a compassionate spirit can change the sense of wellness in a community. My “why” is that I am called to be a conduit of God’s presence of hope, justice and healing to my neighbor in promoting the “kingdom on earth as it is in heaven.”

Theological “Why:” Historical Model

A historical theological model that aligns with the chaplain manager role specifically and FaithHealth generally is the three-fold office of Christ.³ Being a Christ-like leader means assuming the “three-fold office of Christ’s mediating work” by

² Jon Sobrino, *Jesus the Liberator: A Historical-Theological View* (Maryknoll: Orbis Books, 1993), 201.

³ As previously named, this is one model that happens to come from the Christian tradition, but this does not indicate that FaithHealth or the chaplain manager role is excluding of other faith or spiritual traditions.

engaging the prophetic, priestly and kingly (managerial) ministries of Christ.⁴ These roles make up the foundation of anointed leadership roles in the Old Testament and Freeman notes that all three were realized in the life of “God’s anointed, Jesus the Christ.”⁵ Through these roles, Christ mediates the New Covenant.⁶ Christ was not anointed, and thus Messiah, only to a managerial role, but to the functions of prophet and priest.⁷ As Christian leaders, we are called to participate in all three roles as well.⁸ As John Yoder⁹ highlights, the frame of the three-fold office, like any metaphor, is not perfect, but it does offer an understanding of faithful leadership dynamics in ministry using a historical framework.¹⁰ This model is particularly problematic in that it is patriarchal, dated, and the royal or kingly aspect of the image is disconnected from Christ’s preferential care for the poor and those at the margins of community. While it certainly has shortcomings in my context as well, I feel that this model needs to be addressed as it has historically shaped

⁴ Curtis W. Freeman, “Mediating Ministry and the Renewal of the Church.” *American Baptist Quarterly*, 31/4 (Winter 2012): 392-409, 396. “Kingly” is a problematic metaphor because of its gendered nature, so for the purposes of this thesis, I will refer to this function as the managerial role.

⁵ *Ibid.*, 393.

⁶ *Ibid.* 395.

⁷ John Calvin, *Institutes of the Christian Religion*, II.15, ed. John T. McNeill and trans. Ford Lewis Battles (Philadelphia: Westminster, 1960), 496.

⁸ Dan B. Allender, “Three Leaders You Can’t Do Without: Why You Need a Prophet, a Priest, and a King,” in *Leading with a Limp* (Colorado Springs: Waterbrook Press, 2006), 187.

⁹ Yoder was critical of chaplaincy in his work, *Church and State According to a Free Church Tradition*, encouraging the Church to not serve as a chaplain blessing everything. Rather, Yoder encourages the church to live into its prophetic role. See *Church and State According to a Free Church Tradition* at <https://chamberscreek.net/library/yoder/freechurch.html>.

¹⁰ John Howard Yoder, *Preface to Theology: Christology and Theological Method* (Grand Rapids: Brazos Press, 2002), 239.

the image of leadership and the ministerial role of clinical spiritual care providers and those serving in social justice ministries.

As I think about my leadership through the lens of the threefold office of Christ's ministry and leadership, I see evidence of prophetic, priestly and managerial ministry. However, my context within a medical center and personality lean significantly toward priestly and management ministries. But, perhaps the "why" of this theological framework as it relates to chaplain managers is the prophetic role.

I often hear chaplains express a lack of opportunity to engage the prophetic ministries of Christ. Within traditional chaplaincy settings, especially in areas with high patient to chaplain ratios, there is little time to engage any office except the priestly role.¹¹ FaithHealth and the role of chaplain managers provide avenues for chaplains to engage the prophetic and managerial offices. These roles of distinctly part of this integrated model and the three-fold office provides theological framing for the necessity of engaging each part of Christ-like leadership. To clarify, I am not suggesting the traditional model of chaplaincy was only priestly; however, the new model encourages chaplains to occupy each office. The integrated model of FaithHealth has Christ-like leadership at its foundation and I believe it is one of the most compelling reasons to adopt this model.

Theological "Why:" Relational Model

¹¹ In returning to Yoder's point, often chaplains are discouraged from engaging in the prophetic while assuming the role of institution representative and encouraged to do so as a representative of their own faith tribe.

While the three-fold office of Christ serves as a helpful model of appreciating the function of chaplain managers, it is again a dated model that is patriarchal in nature. Bonnie Miller-McLemore offers another theological image that illumines this integrated model of chaplaincy and spiritual care. Miller-McLemore's metaphor of pastoral theology as a *living human web* is a critique of Anton Boisen's image of a "living human document."¹² According to Miller-McLemore, the "metaphor of the living human document tried to address the first challenge [of the living human document] of irrelevant theology, and the metaphor of the living human web hoped to respond to the second challenge of political and social injustice."¹³ In other words, the image of a living human document recalls the human person among the dogmatics of theological discourse and the living human web is a reminder that the human document is connected to other documents and stories within and beyond its own context.

Miller-McLemore's model of a living human web sought to "shift from a focus on care narrowly defined as counseling...to a focus on care understood as part of a wider cultural, social, and religious context."¹⁴ Such a shift redefines and takes seriously the impact of the "public web of constructed meaning," and invites other social sciences in addition to psychology into the web of interpretation.¹⁵ The FaithHealth spiritual care model specifically invites the public health discipline to the table of interpretation,

¹² Bonnie J. Miller-McLemore, "The Living Human Web: A Twenty-Five Year Retrospective," *Pastoral Psychology* 67, no.3 (2018), 308.

¹³ *Ibid.*

¹⁴ *Ibid.*, 311.

¹⁵ *Ibid.*, 313.

offering both a tool to better understand the living human web as well as offering another bridge of vocabulary between spiritual care providers and other healthcare professionals. Furthermore, this model retains a mission to care for individuals, but extends that ministry to care for webs of people in community and challenges structures that disconnect people from health. Thus, spiritual care in this model means attending to “the knowledge of those underprivileged, the outcast, the underclass and the silenced.”¹⁶

As with any theological model, the living human web has its own limitation. One such limitation lifted by Miller-McLemore in her twenty-five year retrospect on the model is how it adds significantly to the already-full plates of ministers. According to Miller-McLemore, ministers informed by this models “will now have to know how to analyze communal resources, enter and organize communities for action, and balance ministry to individuals in crisis with social advocacy.”¹⁷ The challenge Miller-McLemore names is a challenge FaithHealth encounters, too; namely, encouraging specialists in chaplaincy and psychotherapy to continue their important individualized work while adopting a generalist vision for engaging the particular needs of community members. Not only does this work further diversify the patient or client load of chaplains and counselors, but also challenges individuals to healthily venture outside the purview of their professional identities.

Pamela Cooper-White offers a parallel framework that hinges on the connectedness of creation, but her relational theology emphasizes the coconstructed

¹⁶ Miller-McLemore, “The Living Human Web,” 315.

¹⁷ *Ibid.*, 317.

intersubjective space between us, our neighbors, and God.¹⁸ According to Cooper-White, “If we accept the concept of the relational dimension of consciousness and its construction, our theology can be similarly understood as a mutual, coconstructive, cogenerative yearning between humans and the divine.”¹⁹ Rather than a silent, static being, God is multiple, fluid, and relationally present within and among humanity.²⁰

Being an active, participatory theology does require expanded capacities to hold and engage complexity, empathy and mutuality, patience, emancipatory listening and silence.²¹ Engaging complexity is being attentive to multiplicity and recognizing that the praxis of theology is in holding multiple realities and identities simultaneously.²² The reevaluation of subjectivity in this model seeks to recognize and know God and others through empathy and experience rather than mere objective observation and such relationships require intentional listening and speaking.²³ Cooper-White also proposes that a relational theology includes patience, emancipatory listening, and silence to recognize that life is a process and it involves justice and respect for difference. Cooper-White states, “If God’s own being is to be understood as multiple, fluid, relational, and in process, encompassing difference, then we will be attentive to finding God’s own

¹⁸ Pamela Cooper-White, *Shared Wisdom: Use of the Self in Pastoral Care and Counseling* (Minneapolis: Fortress Press, 2004), 186.

¹⁹ *Ibid.*, 184.

²⁰ *Ibid.*, 186.

²¹ *Ibid.*

²² *Ibid.*, 187.

²³ *Ibid.*, 188.

self/selves also in the gaps [of difference] and on the margins [of society].”²⁴ Our understanding of our relationship with God and our neighbors pull us “toward places where exclusion, oppression, and human suffering convict us and pierce our hearts with the cry for solidarity and agapic love.”²⁵

The FaithHealth model is one of collaboration that initiates relationships from the vantage point of curiosity. Too often healthcare agencies approach community health from a top down perspective rather than listening empathetically and curiously for root problems and community assets. The FaithHealth chaplain manager role employs relational theology’s praxis of tending to complexity, offering empathy, and joining in the coconstructive, relational space between God, oneself, and others to address sources of human suffering and hope. Furthermore, the role itself carries out a multiplicity of identities, namely, chaplaincy, community engagement, and counseling, that includes both functions of a specialist and generalist in ministry. Since community calls for all of us to be coconstructed, intersubjective, space, FaithHealth recognizes that we are only as healthy and whole as the most vulnerable and marginalized in our community. To carry on a previous image, we are not all the same, but we are connected and our lives impact our neighbors.

Vocational “Why”

FaithHealth’s chaplain manager role is an evolved role that encompasses population health and value-based health care. Rather than ministering to the individuals

²⁴ Cooper-White, *Shared Wisdom*, 189.

²⁵ *Ibid.*, 193.

separately, population health focuses on the health outcomes of groups or communities. Value-based healthcare focuses on what medical centers like Atrium Health Wake Forest Baptist has focused on since its inception; operating out of a mission to partner with communities in the delivery of healthcare. Chaplains and counselors need to be part of this movement. While transitional models of care are necessary, trauma theories and increasing dialogue among spiritual care providers recognize the necessity of proactive community care.²⁶

Strengths and Challenges

The FaithHealth chaplain manager model offers both strengths and challenges. First among the strengths is that it is holistic in nature, encompassing clinical spiritual care, counseling, and community engagement. This blended role provides space for chaplain managers to serve as traditional spiritual care specialists and embrace the generalist roles of other ministries. For instance, clinical spiritual care is no longer held to the confines of a hospitalization, but includes connecting individuals to a broader array of supportive structures within one's community. This allows chaplain managers space to offer a broader range of services to support patients. Such an array of services offered through webs of trust proved vital to patient care and community health during the coronavirus pandemic.

Second, the FaithHealth chaplain manager role increases the ministry of spiritual care providers by increasing spiritual care staffing. For small community hospitals that struggle to budget for a full-time chaplain, behaviorist, and community health worker,

²⁶ Of note, I am referring to Protestant medical centers or those unaffiliated with faith groups. Catholic health systems have had a robust system of community health in place for some time.

this model offers a full-time position that increases the visibility and impact of the role. This model provides holistic care for patients, an increased spiritual care presence and impact in community, and full-time employment for chaplains in a saturated market.

Finally, the FaithHealth chaplain manager role offers an evolution of the spiritual care profession that includes connecting or reconnecting with the church and other helping professions. Furthermore, it offers a platform of integration in reimagining the training of future professionals in graduate school and program such as Clinical Pastoral Education (CPE). The FaithHealth chaplain manager role returns in some ways to the connection found between chaplaincy and counseling in the twentieth century and to the connection between chaplains as extensions of the Church in the medical center setting, at least in the Christian Church. The chaplain manager role reclaims the generalist role of ministry within the specialized function of chaplaincy and counseling. In addition, many seminaries and divinity schools offer dual degree programs in divinity and social work or a graduate counseling program. This role could offer students interested in both counseling and chaplaincy a place to streamline state licensure and board certification into a manageable, holistic program.

There are also challenges to the FaithHealth chaplaincy model. As displayed throughout the history of Atrium Health Wake Forest Baptist, this is a model that builds upon an established relationship between clinical spiritual care and community agencies and places of worship. Entities without such a missional paradigm or those without a tenured spiritual care department may struggle to establish the relational capital necessary for this program's success. Furthermore, the FaithHealth model of chaplain managers works well in community hospitals in smaller towns where the medical center is attached

to a larger academic medical center. This model, at least in the same fashion as it exists at Atrium Health Wake Forest Baptist, does not have a history in for-profit hospitals or those in urban areas.²⁷

Another challenge shared by chaplain managers at Atrium Health Wake Forest Baptist is that holding multiple hats and being responsible for managing and carrying out the ministry of FaithHealth is taxing. Chaplain managers minister to patients, visitors and staff as traditional hospital chaplains, but also have a community engagement caseload and some have counseling clients. Chaplain managers within Atrium Health Wake Forest Baptist generally have fewer patients to care for than traditional hospital chaplains quantitatively, but they offer and manage care through a variety of roles and responsibilities. For instance, maintaining boundaries, confidentiality and treatment-oriented interventions in counseling is a different contract than one initiated in chaplaincy and as a community health worker. While I think this is certainly a model that serves patients, practitioners and medical centers well, there are areas of challenge that need mitigating in the context of the medical center and broader community.

Context Matters

First, my own disclaimer: I am a white, southern, progressive Baptist, heterosexual male that serves as a chaplain manager in a community hospital tied to an academic medical center in the Piedmont of North Carolina. When I am not at work, I am spending time with family on our farm which serves both as a beacon of solace and a

²⁷ FaithHealth has roots in Memphis, Tennessee, so the model works in urban areas. However, the exact model of chaplain managers represented at Atrium Health Wake Forest Baptist was not in the same function in this iteration. Furthermore, the work of Jay Foster at Indiana University Health represents the newest iteration of this model in a different context.

reminder of the gift of hard work. While my work is spiritual and interfaith in nature, I write this thesis as an ordained Christian minister completing a Doctor of Ministry degree from a school affiliated with the United Methodist Church. Despite efforts to address my own assumptions and biases, this work is contextually connected to my story and the experience of persons who predominately look like me. And, despite efforts to diversify voices in the field of spiritual care and counseling, the foundational roots of both disciplines are normed to those who experience the word in much the same ways as I do. My hope is that this work contributes to diversity in the delivery of spiritual care as much as it situates itself among a host of diverse professional voices.

On the other hand, I work in the same small community of which I grew up and I generally know or recognize the language of persons in this community. I would be lying if I did not include conversations around cows, bees, the county's one high school athletic program or the need for rain as rapport-building interventions with those I serve. Having a history with people can serve as a gift or a limitation. It is a true gift when those scared to see the doctor see a familiar face or when relationships of trust positively influence persons on the fence about the COVID-19 vaccine. Having a history with people can also serve as a challenge. Dual relationships take new definitions in small town U.S.A and lines between being seen as a professional in one's hometown can be challenging.

Again, the FaithHealth chaplain manager role is one that is contextually located but adaptable to a variety of contexts. The key, at least theoretically and speaking from my own experience, is to be a student of culture and a trusted partner in a community's webs of relationships.

The aim of this thesis is to present a model of spiritual care that stretches beyond the medical center in an embrace of community health. It is not intended to be the answer to chaplaincy and counseling's embrace of values-based care and population health, but it is a model that works especially well within our historical and current contexts and offers a glimpse of opportunity for the future of clinical spiritual care professions. I encourage the reader to read this thesis with your own context in mind; take elements of the FaithHealth chaplain manager role that you believe would work well in your areas and leave other elements behind. May this story be one among many of faithful ministry in today's context.

Chapter One

Historical Location

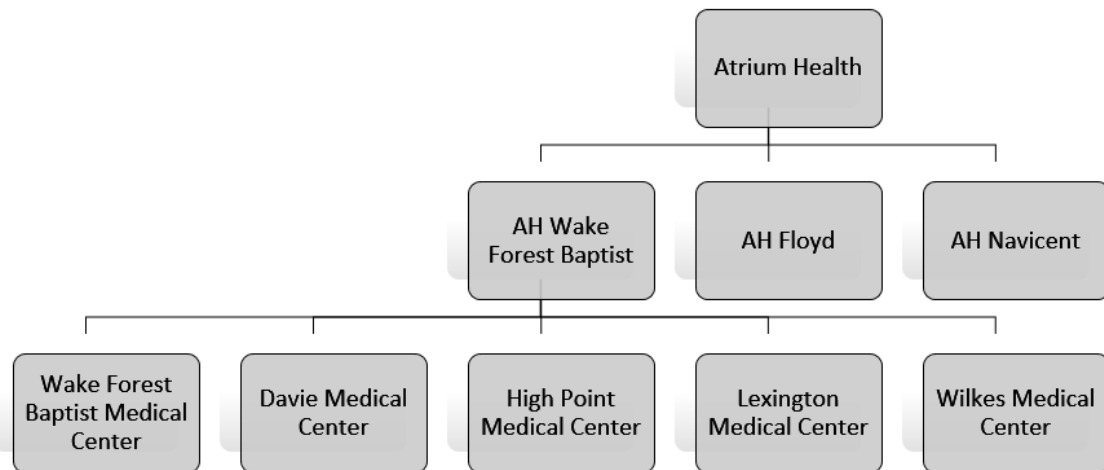
The division of FaithHealth (hereafter called the FH division) at Atrium Health Wake Forest Baptist has a rich history of innovation within the disciplines of pastoral care, pastoral counseling, and community engagement. As a leader in the praxis-oriented theological education movement and spiritually-integrated community engagement, the FH division continues to have a large footprint in academic and professional circles. Through an exploration of its foundations and an analysis of its current state, it is clear that the FH division has leveraged its innovative history to provide future opportunities for academic excellence and a pioneering spirit in the minister of spiritual care.

Atrium Health Wake Forest Baptist: The Beginning

Bowman Gray School of Medicine was founded as a two-year medical school in 1902 on the campus of Wake Forest College in Wake Forest, NC. Twenty-one years later, North Carolina Baptist Hospital opened as an 88-bed hospital in Winston-Salem, NC.¹ The only shared identity between these entities was their connection to the Southern Baptist Convention through the Baptist State Convention of North Carolina. The influence of J. B. Duke and the founding of Duke Medical School sparked a negotiation between Bowman Gray and R. J. Reynolds to combine these entities in Winston-Salem.

¹ “Our History,” Wake Forest Baptist Health, accessed July 20, 2020, <https://www.wakehealth.edu/About-Us/History>.

In 2019, Atrium Health Wake Forest Baptist² was licensed for 1535 inpatient beds and recorded 1.98 million outpatient visits. The medical center employs 19,220 people, 39 of which are chaplains within the medical center’s six campuses.³ The religious breakdown of chaplaincy staff and students represents two mainline religions and nine different Christian denominations.⁴ In October of 2020, Wake Forest Baptist Health and Atrium Health formed a single enterprise under the name Atrium Health. The Wake Forest region of Atrium Health now operated under the name Atrium Health Wake Forest Baptist.

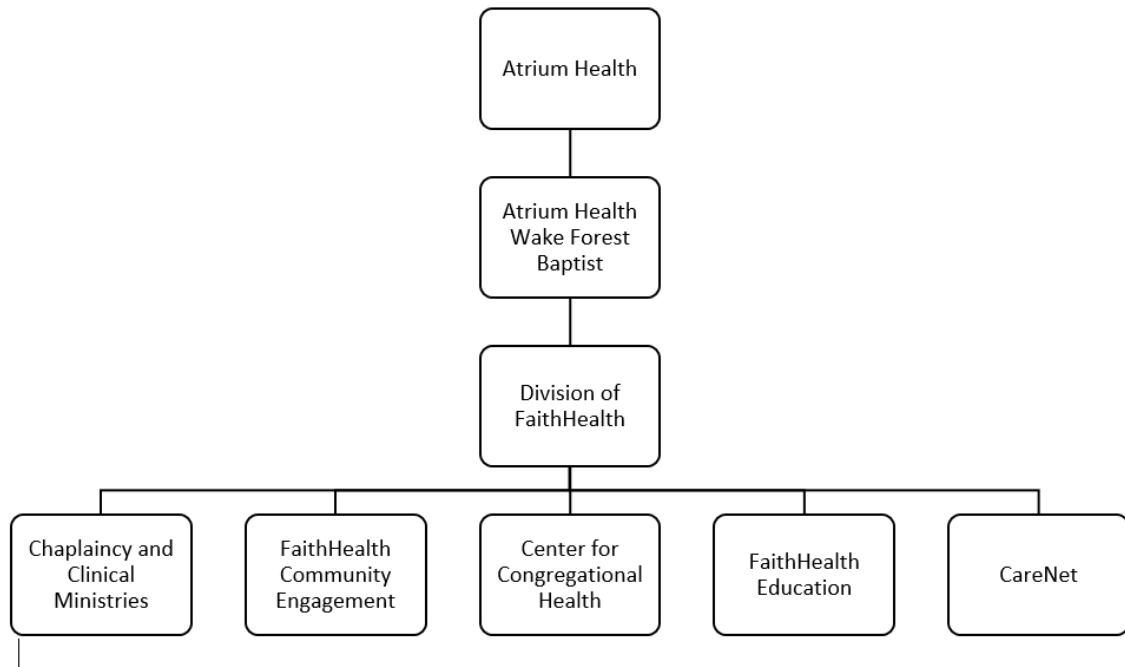


² Atrium Health Wake Forest Baptist is the current name for the combined Atrium Health Wake Forest Baptist Medical Center and Wake Forest University School of Medicine. Throughout this chapter, the reader will notice references to Bowman Gray Campus and North Carolina Baptist Hospital as reflective of the entity’s name in that time period. Likewise, the School of Pastoral Care, the School of Pastoral Counseling, and the Department of Pastoral care are synonymous with the FH division during their time.

³ “Our History,” Wake Forest Baptist Health.

⁴ Emily Viverette, email exchange, November 8, 2021. The two religious denominations are Christian and Buddhist. Those who identify as Christian are affiliated with the following tribes: Baptist, Presbyterian, ELCA, non-denominational, United Methodist Church, Disciples of Christ, United Church of Christ, Moravian, and Seventh Day Adventist.

The School and Department of Pastoral Care at North Carolina Baptist Hospitals is the oldest chaplaincy program in the south and has been a primary driver of a holistic delivery of healthcare. The department has long been recognized as “playing a major role in reflecting the spirit of the medical center in seeking to actualize the healing ministry of Jesus; taking seriously the treatment of the mind, body, and spirit.”⁵ Today, the FH division houses the departments of Chaplaincy and Clinical Ministries, CareNet Counseling, Community Engagement, FaithHealth Innovations, and the Center for Congregational Health.



Pastoral Care at North Carolina Baptist Hospital

⁵ Manson Meads, *The Miracle on Hawthorne Hill: A History of the Medical Center of the Bowman Gray School of Medicine of Wake Forest University and the North Carolina Baptist Hospital* (Winston-Salem: Wake Forest University, 1988), 92.

The early connection between Baptist Hospital and the Baptist State Convention developed naturally through the churches' pride in the formation of the hospital and the hospital's dependence on Baptist churches for moral and financial support.⁶ The Women's Missionary groups, along with other Baptist State Convention programs, took a primary seat in fundraising efforts for the new hospital. Rev. G. T. Lumpkin, a Baptist pastor, was the first hospital superintendent and he devoted a portion of his time to ministering to the spiritual needs of patients in the hospital.⁷ Lumpkin's successor was Smith Hagaman, a lay person who did not feel comfortable offering spiritual care in the same way Lumpkin offered through his role. Hagaman made the first official move toward securing a hospital chaplain in 1940. The board minutes from July 18, 1940 read: "Mr. Hagaman, the superintendent, reports that a Baptist layman has agreed to pay the salary of a resident minister at the hospital to administer to the spiritual needs of the patients and the hospital force."⁸ Rev. C. E. Parker was hired four months later at an annual salary of \$1,600.⁹

Parker and Hagaman shared in the responsibility of maintaining denominational relations from 1940 – 1944, attending 80% of the Baptist associational gatherings in North Carolina in addition to their on-campus responsibilities.¹⁰ But by 1945, the responsibilities of hospital leadership and denominational affiliation needed realignment

⁶ Meads, *The Miracle on Hawthorne Hill*, 179.

⁷ Ibid.

⁸ Ibid., 180.

⁹ Ibid.

¹⁰ Ibid., 181.

to sustain the institution's growth. The board of trustees voted to appoint a Director of Religious Activities and Denominational Relations and merge the Office of Chaplain with the Office of Denominational Representative.¹¹ The duties of this appointment were as following:

[The director is] responsible for a Program of religious activities for employees and student nurses, including vespers and chapel services and periodic Religious Emphasis Weeks; for regular visitation of hospital patients as well as being on call for emergency care; for serving as liaison between patients and hometown pastors; for being available for special conferences with patients; for editing *Baptist Hospital News* and a special page to be mailed from the W.M.U headquarters in Raleigh; for preparing all literature to promote the Mother's Day offering, for speaking in churches, attending associational meetings and other denominational meetings; for generally serving between the hospital and pastors/churches; for teaching a course in Bible to student nurses; and for general support of the hospital's programs. The director also will be responsible for hearing complaints and suggestions from patients and communicating with the appropriate staff members in trying to resolve these problems.¹²

The first director of the Department of Religion and Denominational Affairs was Dr. W. K. McGee. By 1946, merely one year into his position, McGee expressed tension between his responsibility with patients and his obligation toward maintaining denominational relations.¹³ This tension increased with the resignation of Parker from the chaplaincy position. McGee told the trustees that there is a need for "at least one [chaplain] in the hospital at all times during the day and on-call through the night available for any special call that might come."¹⁴ He knew this could not be

¹¹ Meads, *The Miracle on Hawthorn Hill*, 181.

¹² *Ibid.*, 182.

¹³ *Ibid.*, 183.

¹⁴ *Ibid.*, 184.

accomplished by one person, especially with out-of-town commitments with the denomination.¹⁵

McGee's search led to the hiring of Richard K. Young as associate director in 1947. Working alongside the student secretary, Edith Arrington, Young and Arrington created the Clinical Pastoral Training Program soon after Young's arrival.¹⁶ By 1953, the Department of Religion and Denominational Affairs divided into the Department of Denominational Activity, which was directed by McGee, and the Department of Religious Activities, directed by Young.¹⁷ McGee and his department created a network of Baptist Hospital representatives that served as a liaison between Baptist Hospital and Baptist congregations in North Carolina. In total, there was one representative for each of the seventy-plus Baptist associations across the state.¹⁸ McGee also set up the Service Patient Endowment Fund to accompany offerings from Baptist churches that financially assisted "needed patients" with the costs of healthcare.¹⁹ Young and those in his department managed hospital ministries, offered pastoral care training, and outpatient counseling.²⁰ Young described the training program's courses as being offered "in the

¹⁵ Meads, *The Miracle on Hawthorn Hill*, 184.

¹⁶ *Ibid.*, 185.

¹⁷ *Ibid.*, 186.

¹⁸ *Ibid.*, 187.

¹⁹ *Ibid.*, 188.

²⁰ *Ibid.*, 187.

conviction that there are values to be derived from a clinical study of emotional problems which cannot be obtained through a theoretical approach.”²¹

Rev. Benjamin Patrick was employed as director of the pastoral counseling services in 1954. Dr. Albert Meiburg was also hired as a researcher in the growing discipline of pastoral care and counseling.²² Young and Patrick published “Out-Patient Pastoral Counseling in a Medical Center” in *The Journal of the American Medical Association*. The article caught the attention of the senior editor of the *Reader’s Digest*, Dr. Clarence Hall, who worked with Young and Meiburg to produce “Spiritual Therapy: Modern Medicine’s Newest Ally” for the September 1959 edition of the *Digest*.²³ The *Winston-Salem Journal* reported Hall praising Young in making “the greatest discovery of modern psychiatry, the soul – not as another name for the mind, but an area in its own right, affecting mind and body for the good or ill.”²⁴ By the following year, the department produced a film entitled *A Guide to Hospital Visitation*. It circulated pastoral care study groups and was featured by NBC and Radio and Television Commission of the Southern Baptist Convention under the title of *From the Most High Cometh Healing*.²⁵

Young also served as an essential part of the 1961 Committee for a Model Community in partnership with Charles Babcock and Marshall Kurfees, the seated Winston-Salem mayor. Through this community program, Young led the effort to

²¹ Richard K. Young, *The Pastor’s Hospital Ministry* (Nashville: Broadman Press, 1954), 132.

²² *Ibid.*, 195.

²³ *Ibid.*

²⁴ “Teaching By Dr. Young Praised by Magazine,” *Winston-Salem Journal*, August 24, 1959.

²⁵ Meads, *The Miracle on Hawthorne Hill*, 196.

establish “Meals on Wheels,” a program to increase literacy rates called “Each One Teach One,” and provided financial support for student chaplains ministering at Goodwill Industries and the Juvenile Detention center.²⁶

The Department of Human Enrichment and Development joined the FH division in 1973 under the leadership of M. Mahan Siler. The focus of this program was to emphasize “prevention of illness in the ministry of pastoral care.”²⁷ Using growth and enrichment experiences through what was known as Shalom Events, the department offered 30 short-term events with 503 participants in 1974.²⁸ The division of Pastoral Counseling also grew exponentially during this era through the work of Ted Dougherty and pastoral counseling supervisor Daniel Jungkuntz.²⁹ By 1974, the division of Pastoral Counseling instituted a fee system for the primary purpose of the therapeutic benefit of clients taking responsibility for their work in counseling. This sliding scale fee system helped establish satellite pastoral counseling centers across North Carolina.³⁰ The initiation of the Ministers Care Plan, a contractual agreement with North Carolina Baptists, Moravians, the United Church of Christ, and the Western North Carolina Conference of the United Methodist Church, culminated the work of pastoral counseling and the Department of Human Enrichment and Development to care for ministers and their families in North Carolina.³¹ The division for Human Enrichment ultimately

²⁶ Meads, *The Miracle on Hawthorn Hill*, 197.

²⁷ *Ibid.*, 200.

²⁸ *Ibid.*, 204.

²⁹ *Ibid.*, 200.

³⁰ *Ibid.*, 203.

³¹ *Ibid.*, 206.

envisioned the community-based pastoral counseling program that eventually became CareNet Counseling.³²

Anton Boisen and Clinical Pastoral Education

Anton Boisen is widely regarded as the father of the clinical pastoral education movement. He was diagnosed in 1920 with schizophrenia after a period of hallucinations and delusions and was hospitalized at Boston Psychopathic for the first of five hospitalizations.³³ During his initial hospitalization, Boisen discovered his calling through his own unsettling experiences that were often religious in nature.³⁴ The former History Manager of the Association for Clinical Pastoral Education, Inc., Robert Leas, identifies Boisen's call and the fruits of it as "break[-ing] down the dividing wall between religion and medicine."³⁵ Boisen reached the conclusion that he could not be effectively treated without accounting for the religious and philosophical nature of his condition.³⁶ Boisen began searching for ways to introduce seminary students to the "living human documents" of psychiatric patients and their experiences in the hospital.³⁷ While records show no evidence for Boisen physically visiting North Carolina Baptist Hospital, his influence was present through two of his students, Wayne Oates and Richard Young.

³² Mark Jensen, phone interview, July 24, 2020.

³³ Robert C. Dykstra, *Images of Pastoral Care: Classic Readings* (St. Louis: Chalice Press, 2005).

³⁴ *Ibid.*, 2.

³⁵ Association for Clinical Pastoral Education, "A Brief History."

³⁶ *Ibid.*

³⁷ Dykstra, *Images of Pastoral Care*, 16.

Educational Identity: The School of Pastoral Care

McGee's board report in 1952 praised the Clinical Pastoral Training Program as being recognized as "the finest of its kind in the country."³⁸ Young graduated from Southern Baptist Theological Seminary where he studied the correlation between the insights of psychology and the behavioral sciences and theology.³⁹ During his time at Southern Seminary, Young's classmate Wayne Oates received clinical training at Elgin State Mental Hospital under the direction of Anton Boisen.⁴⁰ The summer of 1947 marked the first clinical training course at Baptist Hospital and in the south under the supervision of Young and Oates.⁴¹ The curriculum included didactics, case studies, assigned reading and skill seminars focused on ministering to particular patient populations. An educational emphasis was placed on the "living human document" of patient encounters within the clinic.⁴² Each student covered twenty-five hospital beds and assumed full responsibility for providing spiritual care. Students in the pastoral care program "had access to the chaplain or a psychiatrist on the medical staff of the hospital if he wishes a better understanding of his own personality reactions in order to render a more effective ministry to others."⁴³

³⁸ Meads, *The Miracle on Hawthorne Hill*, 185.

³⁹ *Ibid.*, 190.

⁴⁰ Richard K. Young Memorial Fund pamphlet within the division of FaithHealth.

⁴¹ Meads, *The Miracle on Hawthorne Hill*, 190.

⁴² *Ibid.* "Living human document" is an image used by Boisen to describe the work of pastoral care providers within a hospital setting. For further reading, see Robert C. Dykstra's *Images of Pastoral Care: Classic Readings*.

⁴³ Richard K. Young, *The Pastor's Hospital Ministry*, 134.

Young returned to Southern Seminary in 1948 to complete his Doctor of Theology degree and publish his first book, *The Pastor's Hospital Ministry*.⁴⁴ His work was one of few books to inform ministers about hospital ministry and led to a two-week hospital chaplaincy conference at North Carolina Baptist Hospital in 1952 with chaplains from thirteen hospitals across the south.⁴⁵ This training led to a three day institute on pastoral care through a sponsorship of Bowman Gray and Baptist Hospital, marking what *Twin City Sentinel* named "the first of its type in the south."⁴⁶ Young described these trainings and his clinical work with students as a program "designed to knock off some of the rough edges as far as personal idiosyncrasies that impair full use of one's self as a minister."⁴⁷ These trainings and the clinical course offered a glimpse into the educational hub developing at the North Carolina Baptist Hospital with its local and regional impact.

The CPE program was first accredited by the Association for Clinical Pastoral Education in 1967.⁴⁸ Young retired soon after for medical reasons and Andrew Lester filled his position. During Lester's years of service, the School of Pastoral Care increased its participation in the Association for Clinical Pastoral Education with Bowman, McGee, Wesley Brett and Maurice Briggs occupying executive leadership roles within the association. The department also established a master's degree program in pastoral

⁴⁴ Meads, *The Miracle on Hawthorne Hill*, 191.

⁴⁵ *Ibid.*, 192.

⁴⁶ *Ibid.*, 192.

⁴⁷ *Ibid.*, 184.

⁴⁸ *Ibid.*, 199.

counseling at Wake Forest University.⁴⁹ In 1974, Ted Dougherty's expansion of the satellite centers of the Department of Pastoral Care provided a means of offering training in pastoral counseling through the Association of Clinical Pastoral Education. Counselors in this program were recognized and certified through the American Association of Pastoral Counselors and/or the American Association of Marriage and Family Therapists.⁵⁰

From its foundation, education has served as the cultural center for the division of Pastoral Care. Today, CPE within the FH division is part of Wake Forest University School of Medicine and offers internships, residencies, and supervisory education programs. CareNet Counseling, the spiritually integrated counseling department of the FH division, offers a two-year spiritually-integrated counseling residency that resembles a CPE pedagogy for provisionally licensed mental health counselors, clinical social workers, and marriage and family therapists. The Center for Congregational Health, which was officially launched in 1992 but had significant roots in the human enrichment division, offers training throughout the southeastern United States on intentional interim ministry, professional coaching, and congregational consulting. According to Mark Jensen, Associate Professor of Pastoral Care at Wake Forest University School of Divinity and an ACPE Supervisor at Atrium Health Wake Forest Baptist, the School of Pastoral Care "kept building programs to come get a shingle [certificate] for," but people

⁴⁹ Meads, *The Miracle on Hawthorne Hill*, 200. Mark Jensen later transitioned the MA program into a dual MA/MDiv program through a partnership between the School of Divinity and the Graduate Counseling Program during the formation of the Divinity School. This transition allowed graduates of the program opportunities to pursue North Carolina counseling licensure through its CACREP accreditation. Jensen coordinates the dual degree program in divinity and counseling at Wake Forest University.

⁵⁰ *Ibid.*, 201.

continue to pursue education within the FH division because “the education offered is personally and professionally transformative.”⁵¹

While there is not a nationally recognized credential in the public health roles mirroring board certification in chaplaincy or licensure in counseling yet, the educational wing of FaithHealth offers praxis-oriented education for those serving at the intersection of ministry and population health. Making up a quarter of the FH division, the department of Community Engagement already provides community health worker training and population health training to partnering congregations. In many ways, these trainings represent the commitment to being at the forefront of pastoral care education that sustains the growth and impact of the division.

Jensen mentioned another logic to the role of education, and it centered on the telos of education within the FH division. Since the time of Richard Young’s leadership, the School of Pastoral Care has provided training for specialized ministry. CPE students have a minimum of a Master of Divinity and counseling students have a Master of Arts in counseling or a Master of Social Work. The role of the CPE and pastoral psychotherapy programs was to provide the experiential and intrapersonal learning to excel in a career path. Likewise, the Center for Congregational Health’s training programs centered on those already in a full-time ministry seeking a niche skillset. The community worker training follows the path of Paulo Freire’s popular education and focuses on educating for community impact rather than for individual or congregational health.⁵² Education within the FH division seems to be reexamining its identity and pioneering the core of pastoral

⁵¹ Mark Jensen, phone interview.

⁵² Mark Jensen, phone interview.

care again as it seeks to remain relevant and spiritually-impactful among today's challenges.

Accreditation and Licensure

The School of Pastoral Care at North Carolina Baptist Hospital predates the three largest associations for chaplaincy, Clinical Pastoral Education, and pastoral counseling. Leaders from the FH division were key contributors to the formation of these organizations and continue to serve in leadership roles within these organizations in 2022. The creation and histories of these organizations reflect the landscape of pastoral care and counseling during the early formation of the FH division.

The Association for Clinical Pastoral Education was formed in 1967 through the merging of four associating entities, namely the Council for Clinical Training of Theological Students, the Institute for Pastoral Care, the Lutheran Advisory Council, and the Southern Baptist Association of Clinical Pastoral Education. The latter was developed by Wayne Oates through his work at the Southern Baptist Theology Seminary. Oates, Young and Edward Thornton were the primary leaders of the association and the core identity was the insistence that “pastoral care functions emerge from a theological foundation and serve to strengthen and correct theological knowledge.”⁵³ The merging of these four groups to create the Association for Clinical Pastoral Education centered around three commissions: standards of practice, an accreditation process for CPE centers, and a certification process for clinical supervisors of CPE education.⁵⁴

⁵³ Association for Clinical Pastoral Education, Inc., “A Brief History.”

⁵⁴ Ibid.

The Association of Professional Chaplains had a similar formation that highlighted a need for standards of practice, identity, and certification. The Association of Professional Chaplains began at an annual meeting of the American Protestant Hospital Associations in 1946 when a group of chaplains were invited to a conversation by Russell Dicks.⁵⁵ By the 1970s, two separate chaplaincy organizations, the College of Chaplaincy and the Association of Mental Health Chaplaincy sought validation from the Commission for Hospital Accreditation to create and implement hospital standards for chaplaincy. Although defeated, the motion was passed in the 1980s, requiring hospitals to implement a process for supporting the spiritual needs of patients. Chaplaincy also progressed numerically as a healthcare profession in the 1980s due to the Medicare inclusion of chaplaincy in hospital reimbursements and a similar reimbursement for the ministry of CPE residents in educational centers. The Association of Mental Health Chaplaincy and the College of Chaplains merge to form the Association of Professional Chaplains in 1998.⁵⁶

The American Association of Pastoral Counselors was formed in 1963 through an international conference of the American Foundation of Religion and Psychiatry.⁵⁷ The association experienced a tumultuous start with leaders such as Frederick Kuether, Howard Clinebell, Wayne Oates, and Seward Hiltner disagreeing on the context of counseling as it related to pastoral care. The American Association of Pastoral

⁵⁵ Association of Professional Chaplains, "A Brief History of the Association of Professional Chaplains."

⁵⁶ Ibid.

⁵⁷ E. Brooks Holifield, *A History of Pastoral Care in America: From Salvation to Self-Realization* (Nashville: Abingdon Press, 1983), 345.

Counselors was initially designed for counseling specialists instead of “ordinary parish ministers.”⁵⁸ Oates and Hiltner argued that pastoral counseling was merely a function of the broader pastoral care ministry within the church. Clinebell argued that pastoral counseling had an “explicit goal of spiritual growth,” but did not clearly differentiate between the work of a pastoral counselor and one of other psychotherapists.⁵⁹ Kuether argued that counseling was not a means of pastoral care, but merely dealt with religion as a dimension of personal problems. He believed that counseling “might well be a means to free individuals from the constraints of the institution [of religion].”⁶⁰

As of February 26, 2019, the American Association of Pastoral Counselors merged with the Association for Clinical Pastoral Education.⁶¹ While the American Association of Pastoral Counselors offered a fee-based pastoral counseling certification to its members, the patchwork of state counseling licensure requirements and the financial need for counselors being included on insurance panels endangered the life of the association for years.⁶² According to Jensen, the Association of Clinical Pastoral Education might have followed a similar financial struggle if it wasn’t married to healthcare through its Department of Education accreditation and if it did not receive Medicare pass through funds for educational sites.⁶³ These transitions, and the potential

⁵⁸ Holifield, *A History of Pastoral Care in America*, 345.

⁵⁹ *Ibid.*, 346.

⁶⁰ *Ibid.*, 345.

⁶¹ Association for Clinical Pastoral Education, “About APCE.”

⁶² Mark Jensen, phone interview.

⁶³ *Ibid.*

areas to merge and integrate, leave open possibilities for licensure and a certification process that would benefit chaplain managers and their various roles in the future. While I appreciate each organization's intent to clarify its professional acumen, a recognition of the shared history of these organizations and recent developments will hopefully provide new means of association.

Foundations of FaithHealth

The FH division has a rich history of innovation which continues under the visionary leadership of Gary Gunderson. As the current vice president for the division of Faith and Health Ministries, Gunderson founded FaithHealthNC in 2012 as a continuation of his work on the Memphis Model and Stakeholder Health. FaithHealthNC resurrects the partnership between clinical spiritual care and community engagement through an intentional focus on population health.⁶⁴

Jay Foster coined the term chaplain manager to describe the integrated ministry spiritual care and FaithHealth community engagement that chaplain managers offer at network hospital locations. The first chaplain manager was hired at Lexington Medical Center, followed by Davie and Wilkes Medical Centers within a few years. The term *chaplain manager* correlates within medical center culture to other integrated roles of leadership and practice, such as the role of nurse manager. As later explored in chapter two, chaplain managers carry out of the mission and ministry of the department of

⁶⁴ L. Gregory Jones, *Christian Social Innovation: Renewing Wesleyan Witness* (Nashville: Abingdon Press, 2016). Jones' work on the importance of Christian ingenuity in various institutions speaks directly to the role North Carolina Baptists and Moravians played in creating Atrium Health Wake Forest Baptist as a nationally-ranked academic medical center.

FaithHealth by physically representing the spiritual care and community engagement arms of the division in each context.⁶⁵

Analysis

The formation and history of Atrium Health Wake Forest Baptist offer several themes that speak to the role and function of contemporary pastoral care. Such a history also speaks to possible avenues of continued formation in the future. These themes include: the relationship between mental health and pastoral care and, thus, chaplaincy and counseling; the function of chaplain as leader within the organization; and the role of broader community engagement within a traditionally individualized ministry.

Since Boisen discovered his vocation during an inpatient hospitalization at Boston Psychopathic Hospital, chaplaincy has been connected to counseling, psychiatry, and the broader psychological community. Throughout much of the FH division's history, chaplaincy and pastoral counseling students engaged in similar training programs with a focus on spirituality, introspection, and clinical experiential learning. This model changed in the 1980s due to the rise of managed care and the need for counselors to seek licensure and insurance paneling. However, the Department Chaplaincy and Clinical Ministries and CareNet Counseling continue to be two departments within the same division of the

⁶⁵ As the role of chaplain manager continues to unfold at each location, the title serves both as a strength and challenge. The strength of the chaplain manager title is that it grounds the role in the familiar term, chaplain; when showing up in the center for various needs, it is helpful to have a clearly defined role that has a traditional connection to faith, spirituality, and the medical center context. The term chaplain manager can be a challenge when serving in other specific areas of FaithHealth's ministry. For instance, as a licensed counselor, my email signature and the title most individuals recognize me as is the hospital chaplain, even when I am operating under the role of a counselor. Similarly, when calling patients to assist with various social ministries, it would at times help to have a clearer title for the specific work of FaithHealth. Finally, manager is an administrative term that seems removed from frontline ministry. Generally, I prefer the connection to chaplaincy because it is the predominate function of my work and my personal identity as a minister.

hospital. Furthermore, both educational programs, CPE and the spiritually integrated psychotherapy residency, follow a CPE pedagogy and share in joint leadership. While perhaps too early to assume specifics, the potential merging of the American Association of Pastoral Counselors and the Association for Clinical Pastoral Education may be indicative of a returning partnership between two vocational ministries that operate in different spaces with different contracts but share a common focus on spirituality and holistic care.

Second, chaplains since Parker have worked with hospital administrators to carry out the mission and vision of the medical center to the broader community. In the early years, chaplains led efforts to promote a holistic method of healthcare delivery, took responsibility for the wellbeing of hospital employees, and promoted the care of North Carolina Baptist Hospital beyond Winston-Salem to a broader North Carolina constituency. Today, chaplains within Wake Forest Baptist continue to care for staff members, patients, and their families and continue to have direct lines of communication and influence with key leaders within the organization. This is perhaps most notable in the network hospitals where chaplains lead the Community Health Needs Assessment process as part of the Affordable Care Act, serve as leaders of the clinical bioethics committee, and promote self-care to employees through education and engagement.

Third, since the FH division's inception, community engagement has been a vital external component of the internal spiritual care emphasis. From the Model Community to the department of Human Enrichment and Development, spiritual care has included a communal model that served those socially complex within the greater Winston-Salem area. Through the work of Gary Gunderson, the ministry outside the walls of the hospital

is given equal attention to the needs inside the medical center. While pastoral care as a discipline has always had the behavioral sciences as an accompanying partner, Gunderson is pioneering a new relationship with public health sciences. By engaging the sociocultural aspects of faith in addition to the bio-psycho-social-spiritual model, the FH division is reengaging faith communities across North Carolina in the health and wellbeing of communities.

Atrium Health Partnership

Recently, Wake Forest Baptist Health entered a partnership with Atrium Health, a large multi-state hospital system based in Charlotte, NC. While early in the partnership's negotiations, we are certain Atrium Health is interested in scaling FaithHealth across its 40 hospitals in Georgia, South Carolina, Tennessee, and North Carolina with our current vice president leading the expansion. Atrium employs chaplains in each of their medical centers but the ratio between chaplains and patients is significantly higher than the ratios across the Atrium Health Wake Forest Baptist system, meaning there are less chaplains for more patients. Chaplains in the Atrium system are also not connected to behavioral health or any arm of their population health model. Scaling FaithHealth across Atrium Health will be an endeavor of creating relations, understanding the contexts of community within and outside each medical center, broadening the organizational definition of ministry, and recreating organizational structures while working with a staffing model that resembles our work as chaplain managers within the Wake Forest system. This is exactly why having a substantive understanding of how the theoretical and practical ministry of chaplain managers within Wake Forest is so important.

While I am confident that the integrated model of FaithHealth is effective and efficient, I am concerned about the implications of applying a new model of chaplaincy into hospitals with current models in place. Frankly, I wonder how to frame FaithHealth to chaplains with full agendas who may look at this model as something that removes them further from patient care. That will certainly not be our intent. Quite oppositely, I hope this new framework opens new possibilities for holistic care and more freedom to minister to the unique needs of the community.

Conclusion

The expansion of opportunity sits before the FH division as it continues its strong history of pastoral care. Through redefining the ministry of pastoral care in light of psychological, sociological, theological and public health advancements, the FH division has the opportunity to continue pioneering spiritual care practice and education. May this prayer from Wayne Oates ever ring true in our spirits: “God of peace, grant unto me the discipline and spiritual integrity that reconciliation with you and fellow human beings provides as I take up my cross this day and follow the Lord Jesus Christ. Amen.”⁶⁶

⁶⁶ William Powell Tuck, ed., *A Pastoral Prophet: Sermons and Prayers of Wayne E. Oates* (Macon: Smyth & Helwys Publishing, 2017), 127.

Chapter Two

A New Model of Clinical Spiritual Care

In the fifth chapter of the Gospel of Luke, the writer shares a miracle story in which Jesus heals an individual who is paralyzed. The narrative says that a paralyzed man was brought on a stretcher to be healed, but the crowd surrounding Jesus prevented laying him down before Jesus. Instead, these “neighbors” climbed on the roof and lowered the paralyzed man down through the ceiling tiles to where Jesus was in the middle of the crowd. The Gospel writer records that when Jesus witnessed their faith, he forgave the individual’s sins and instructed him to stand and walk.¹

Chaplain managers are the neighbors in this story. They accompany patients as traditional spiritual care providers by meeting them where they are, bearing witness to the realities of patients and glimmers of God’s presence along their journeys. In essence, they carry out the priestly function. According to Cooper-White, the theological task is “to be with another as a respectful companion and sometimes guide on the journey.”² In addition to the traditional spiritual care role with patients, chaplain managers seek to ensure all patients have access to the same opportunities for healthcare and sometimes find themselves as patient advocates removing the ceiling tiles that limit access to care. By engaging the managerial role, chaplain managers address barriers within the system that hinder the medical center’s ability to care for patients at the appropriate time of

¹ This is a paraphrase of Luke 5:17-26 based on the New Revised Standard Version (NRSV).

² Pamela Cooper-White, *Shared Wisdom: Use of the Self in Pastoral Care and Counseling* (Minneapolis: Fortress Press, 2004), 189.

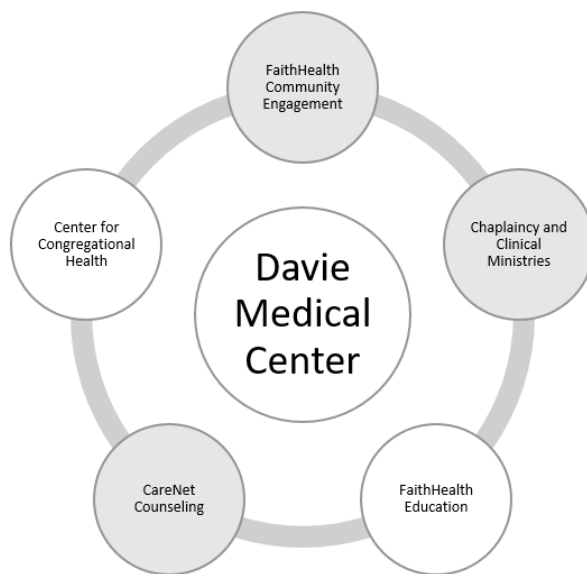
treatment. Chaplain managers also step into the prophetic role by asking of our hospitals, our health systems, and our communities why it takes removing ceiling tiles for some of our neighbors to receive care in the first place. White suggests that chaplain involvement “fulfills a ‘prophetic’ role wherein a chaplain ‘speaks truth to power’ – a task understand to ensure that those with great responsibility are held accountable to more and ethical standards.”³

The qualities of the FH division, namely, holistic healthcare, chaplains’ position of leadership within the organization, and being champions of community engagement, leverage the role of chaplain manager as an integrated spiritual care role. Chapter one explored the unfolding history of spiritual care at Atrium Health Wake Forest Baptist as it aligns with the changing landscape of healthcare in the United States. This chapter will elaborate on the FaithHealth role of chaplain manager as a unique position housed within Atrium Health Wake Forest Baptist’s community hospitals. Since this role encompasses FaithHealth’s relational network of community engagement, a high-level description of each medical center’s contexts is necessary to understand the nuance of this role. Of note, additional information will be provided on the context and ministries of Davie Medical Center as it is my primary ministry context. Sometimes, a multiplicity of roles and functions are necessary to ensure individuals find justice, equity and equality within the healthcare system.

Medical Centers’ Contexts

³ Nathan H. White, “Facilitating Resilience: Chaplaincy as a Catalyst for Organizational Well-Being,” in *Chaplaincy and Spiritual Care in the Twenty-First Century*, Ed. Wendy Cadge and Shelly Rambo (Chapel Hill: The University of North Carolina Press, 2022), 213.

Atrium Health Wake Forest Baptist Medical Center serves as the primary campus of the Atrium Health Wake Forest Baptist region and includes the departments of chaplaincy and clinical ministries, FaithHealth education, community engagement, CareNet Counseling, and the Center for Congregational Health. While representatives from each department of FaithHealth work together in offering care for individuals within the medical center and those beyond its walls, chaplain managers at network campuses manage the ministries of the FH division in the distinct communities of each location. Chaplain managers embody the ministries of chaplaincy and community engagement but serve as connection points for additional departmental services.⁴ Wake Forest Baptist Medical Center also serves as the hub of education within the system and chaplain managers often partner with CPE faculty in educating students both at Wake Forest Baptist Medical Center and at satellite locations.

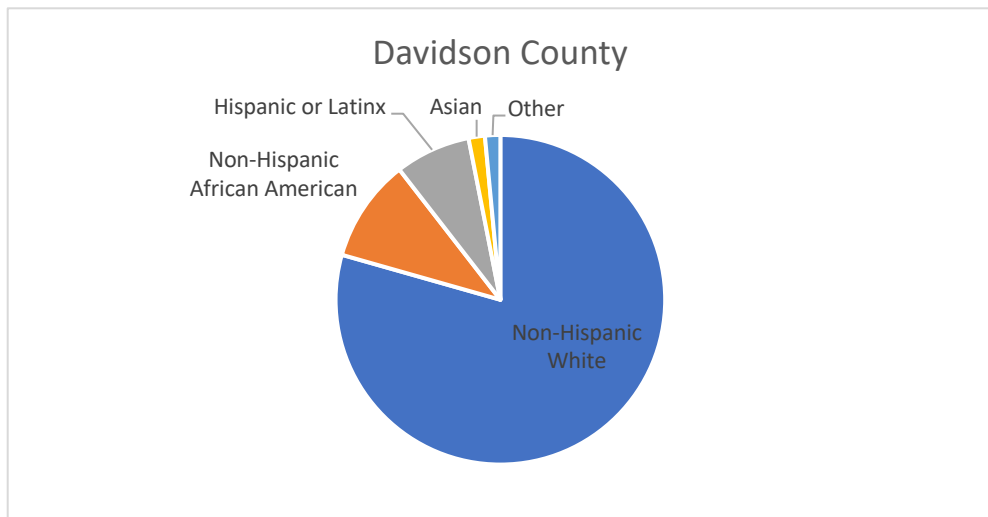


*Filled boxes denote on-site representation

⁴ Davie Medical Center includes CareNet Counseling for on-site support.

There are three chaplain managers within Atrium Health Wake Forest Baptist serving Davie Medical Center, Lexington Medical Center, and Wilkes Medical Center.⁵ While there are other chaplains that serve in management roles at Atrium Health Wake Forest Baptist, the role of chaplain manager as an integrated role that only exists at network campuses. Each chaplain manager reports directly to the Director of FaithHealth Education with additional reporting lines that include each medical center’s president and the Associate Vice President of FaithHealth.⁶ Chaplain managers serve the medical center and county of each satellite campus with additional responsibilities within the FaithHealth division.

Davidson County and Lexington Medical Center



⁵ Atrium Health Wake Forest Baptist High Point Medical Center is another satellite campus of Atrium Health Wake Forest Baptist that has an on-site chaplain manager. Due to the size of High Point’s campus, the chaplain manager at this campus serves more in a traditional spiritual care role that partners with members of the department of community engagement and CareNet Counseling.

⁶ Chaplain managers have a complex reporting structure that represents the matrixed system of Atrium Health Wake Forest Baptist, its community hospitals, and the arms of the FaithHealth division. Such a structure requires its own skillset of recognizing one’s role, which line of leadership needs to be informed, and when to speak up for additional support or name discrepancies.

Davidson County includes the cities of Denton, Thomasville, and Lexington, the county's seat. The county is 553 square miles has a population of 168,930 residents. Of its residents, Davidson County is 79.4% non-Hispanic white, 10.1% non-Hispanic African American, 7.4% Hispanic or Latinx, 1.6% Asian, and 1.5% other.⁷ Additionally, 15.2% of Davidson County's residents identify as person in poverty.⁸ Lexington Medical Center was founded in the 1920s and currently operates a 94-bed acute care medical center. While spiritual care predated the alignment with Atrium Health Wake Forest Baptist, the role of chaplain manager was developed in 2016 with the hiring of its current chaplain. Lexington Medical Center was the first to have a FaithHealth chaplain manager and the community of Lexington was the first impact area of FaithHealth's community engagement. The chaplain manager at Lexington Medical Center is the primary chaplain and manages FaithHealth community. Her team consists of six contract chaplain associates, two contract FaithHealth connectors, and an administrative assistant.⁹

Wilkes County and Wilkes Medical Center

Wilkes Medical Center is in Wilkes County in the foothill's region of North Carolina. The county spans 757 square miles and 65,969 residents call Wilkes County home.¹⁰ Of Wilkes County residents, 86.7% identify as white, 4.7% black or African

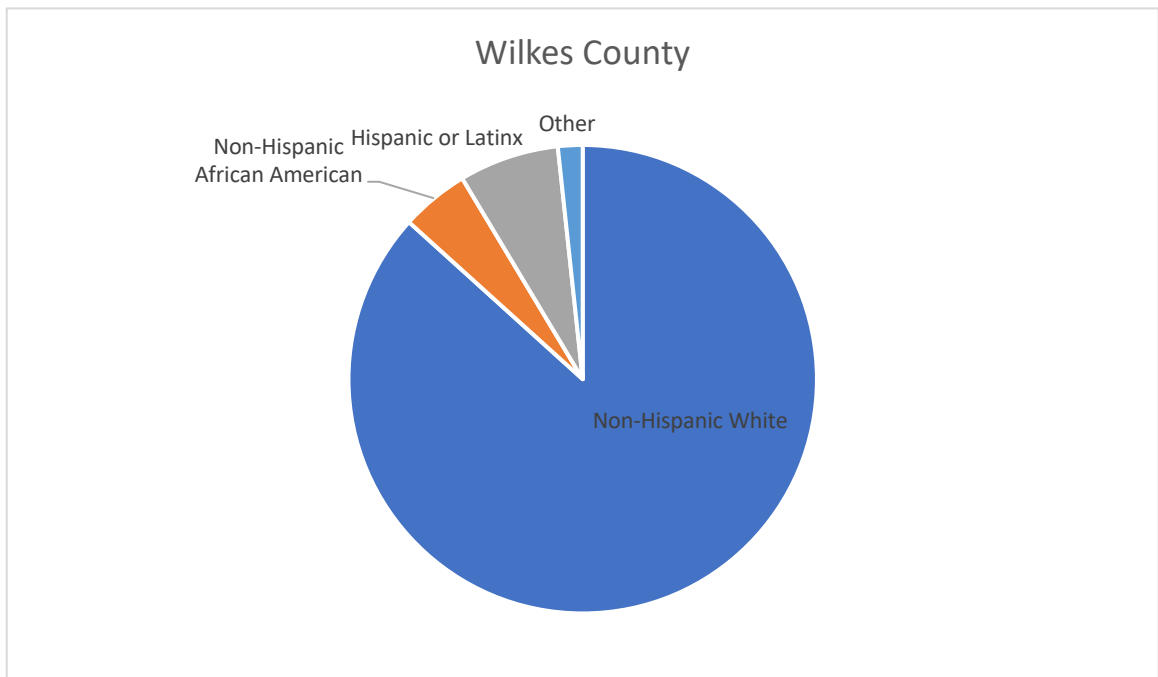
⁷ "Community Health Needs Assessment," Atrium Health Wake Forest Baptist, accessed January 18, 2022, <https://www.wakehealth.edu/About-Us/Serving-Our-Communities/Needs-Assessments-and-Implementation-Reports>. See "Lexington Medical Center CY 2022-2024."

⁸ Ibid. Since poverty is an impoverished metric, a conservative assumption would indicated a much higher margin of actual persons in poverty.

⁹ "Community Health Needs Assessment."

¹⁰ Ibid. See "Wilkes Medical Center CY 2022-2024."

American, 6.9% Hispanic or Latinx, and 1.7% other.¹¹ Additionally, 18.9% of the county’s residents are identified as persons in poverty and 19.4% of children in the county live below the poverty level.¹² Wilkes Medical Center operates 120 acute care beds and ten post-acute care beds in a nursing facility.¹³



Prior to the formation of the current chaplain manager’s role in 2018, spiritual care at Wilkes Medical Center was covered by volunteer clergy from the Wilkes community. Today, the chaplain manager is the chaplain for the medical center and manages FaithHealth community engagement, including supervision for four chaplain associates and three FaithHealth connectors.

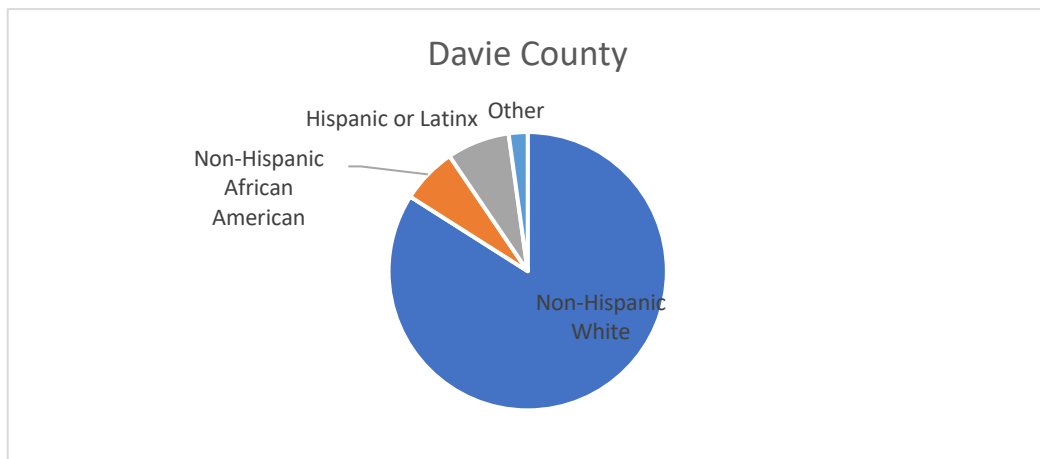
¹¹ “Community Health Needs Assessment.”

¹² Ibid.

¹³ Ibid.

Davie County and Davie Medical Center

Davie County is predominately white, Protestant, and leans heavily toward conservative ideologies both politically and religiously. Davie County’s resident population is 84% white, 7.3% Hispanic or Latinx, and 6.5% black or African American. 10.9% of Davie County are at or below the poverty level.¹⁴ The most notable line of division in Davie County is socio-economic status and the dividing lines split the county into three parts. The first is the western area that continues to merely survive the closing of the textile mill. Poverty and opioid abuse fill the empty streets and grief echoes through the chambers of the dilapidated mill. The second region is predominately farmland, though it also houses the county seat, Mocksville. Farmland in this region is a mixture of a few large commercial growers, struggling family farmers, and those who have spent their lives operating a small farming business. The hospital is located in Bermuda Run, the final region of the county.



This region began as a gated housing development closed off from the rest of the county but annexed within the last ten years to attract local business to the area. Bermuda

¹⁴ “Community Health Needs Assessment.” See “Davie Medical Center CY 2022-2024.”

Run is the outlier in a predominately high-low class to low-middle class status of the remaining communities. While the demographics of Bermuda Run lacks diversity, the medical center is quite diverse as it is connected to an academic medical center. Davie Medical Center offers a better representation of the diversity of the Davie County community than it does Bermuda Run, especially regarding socioeconomic status, age, political affiliations, and ethnicity. Based on 2022-2024 Community Health Needs Assessment, the greatest public health needs in Davie County are access to care, social impact and injustice and chronic and emerging diseases.¹⁵

Atrium Health Wake Forest Baptist Davie Medical Center opened as an outpatient medical center in 2013 and added a 50-bed inpatient unit in 2017. The medical center now operates a medical and surgical unit, and 24/7 emergency department, an operating suite, and an array of ambulatory clinic specialties as part of its medical center campus.¹⁶ Davie Medical Center is the closest to the main campus in Winston-Salem and often has students from various programs rotating through campus. While the smallest hospital of the Atrium Health Wake Forest Baptist, Davie Medical Center is the pioneer and pacesetter for patient and family centered care for the system.¹⁷ Davie Medical Center is

¹⁵ “Community Health Needs Assessment.”

¹⁶ Ibid.

¹⁷ Patient and Family Centered Care is a model of health care that focuses on intentional collaboration between patients, their families and healthcare providers in the diagnosis and treatment process. This model extends beyond the presentation of patients in a healthcare provider’s office or hospital room; it includes information about the patient before the visit and includes support persons in caring for the individual after the visit. For more information, visit www.ipfcc.org to explore the Institute for Patient- and Family-Centered Care.

also the only hospital built by Atrium Health Wake Forest Baptist beyond the Winston Campus.

The initiation of FaithHealth within Davie County began by our team conducting asset mappings with both service providers and service recipients. The areas of disparity discovered within Davie County included a lack of public transportation, an absence of behavioral health providers, and disconnect between faith communities providing services and those provided by non-profit entities. Through the mapping process, a community member noted three churches and two food banks within our county that did not know the offerings of each other, much less have a system to disburse food to those most in need. We also learned that churches had interest in addressing the high suicide rates and low infant mortality rates within our community but did not know how to get involved appropriately.¹⁸ From a different vantage point, providers of mental health services and pediatric health providers felt overburdened and was not aware of the faith community interest in these disparities.

I was hired as the first chaplain of Davie Medical Center in January of 2017, a few months before the opening of the inpatient wing in April. Within one year, we hired two FaithHealth connectors to support community engagement work and four chaplain associates to assist with on-call coverage within the medical center. Today, we continue to have two FaithHealth connectors and six chaplain associates. Davie Medical Center has on-site representation from the departments of chaplaincy and clinical ministries, FaithHealth community engagement, and CareNet Counseling.

¹⁸ Davie County has one of the highest suicide rates per population in North Carolina and Winston-Salem has one of the lowest infant mortality rates within the United States as sited through multiple public health studies.

Chaplain Manager as Practitioner

“The time of death is 1052.”

Earlier that November morning, Sarah¹⁹ was busy carrying out her normal daily routine: she woke up, vomited, woke up her seven-year-old daughter, made breakfast, vomited from the smell of cooking breakfast, dressed herself and her daughter, video called dad, Sam, before he left his third shift job, and loaded up the kids for school. This is the routine of a 26-year-old mom with a seven-year-old daughter who is sixteen weeks pregnant. She dropped off her daughter at school and headed to work at the county health department. Flu season has begun, so Sarah’s day should have been filled with flu vaccinations and charting.

My morning started similarly, but without vomiting. I woke up to a 20-month-old’s arm across my chest. He apparently migrated to our bed at some point through the night as Thanksgiving shook up his and our routine. I changed him out of his pajamas, grabbed something for breakfast, kissed mom goodbye, and we were off to daycare. I arrived at the hospital at 7:45 AM and went about checking patient charts to see what changed over the weekend. I grabbed coffee, attended a meeting, sent a few emails, and was walking toward the inpatient unit when I received a page to the emergency department for an unresponsive patient due to be wheeled through the ambulance entrance at any point. I rarely receive pages before patients arrive, but I shrugged it off as an early “heads up” and walked toward the unit.

¹⁹ The patient’s name was changed to uphold privacy.

Sarah mentioned to her nursing aid that she had a horrible headache but shrugged it off as just another instance of caffeine withdrawal. She's pregnant, of course. Her symptoms rapidly worsened, so she finished with her patient and told her nursing assistant that she needed to lie down for a few minutes. At that point, the nursing aid and her colleague across the table noticed her words slurring and her disoriented movements. They called 911, but Sarah was unresponsive, and CPR was underway by the time EMS arrived. Her colleagues called her husband to have him meet them at the hospital.

She arrived under the status of "CPR in Progress." Our team only knew her name, her pregnancy status, and that CPR was being administered in route. Her spouse wanted to be at his wife's side, so he was ushered in as the orchestra of the medical team continued their work. The attending physician, who has two daughters in elementary school as well, pushed a cocktail of drugs through her system in an attempt to stabilize a heart rhythm. She would stabilize for a few seconds, then rapidly deteriorate. Sam pleaded and bargained with God for the fifty minutes the medical team sought to resurrect her life. I sat beside Sam with an arm over his shoulders. The physician tells Sam that his wife has more than likely suffered an aneurism, a condition with heightened probability given her pregnancy. Sam asks about the baby and the glassy eyes of the physician closed as he shook his head. The gasping noise of chest compressions stopped, monitors silenced, gloves removed.

While similar encounters could be shared widely across medical centers, there were various elements of FaithHealth support that accompanied this patient beyond the specialized work of chaplains. First, Davie Medical Center does not have a child life specialist to assist families with sharing such news with a child. Second, opportunities for

grief counseling were few for this family as the passing of their loved one coincided with a peak of COVID-19 deaths in our area. Third, the patient worked at the health department and medical center employees worked closely with her specific team. Finally, while stricken, the spouse of the patient expressed concern for affording childcare since his salary would not cover the cost of daycare along with his other monthly bills.

The chaplain manager helped the family share of the patient's passing with her daughter and provided the family with age appropriate grief and counseling resources. Additionally, the chaplain manager provided a layer of support to the health department team by offering a debriefing and connecting individuals with counselor in the community. Recognizing the circumstances beyond the trauma of the emergency department, the chaplain manager, with permission from the patient's family, was able to access the web of trusted relationship to assist this family beyond the walls of the medical center by connecting the family with financial resources for childcare. To borrow from Miller-McLemore's image, these webs of trust are living webs that are interconnected and are a real part of this family and community's story.

Chaplain managers are first and foremost practitioners of care. They are trained chaplains with additional on-site training in community engagement and the FaithHealth model. At Davie Medical Center, this role also includes training and licensure in mental health counseling. Chaplain managers are students of their contexts and exercise discernment in wearing the many "hats" they don. This section will explore the primary functions of the chaplain manager role which are chaplain, community engagement and CareNet Counseling.

Chaplain

The primary role of chaplain managers at Davie Medical Center, Lexington Medical Center, and Wilkes Medical Center is to provide spiritual care to patients, their families, and staff members as the primary chaplain of each medical center. Chaplain managers provide spiritual care in a variety of forms. They round on patients and staff members throughout the medical center and provide consultative services through clinical referrals for patient visit. Chaplain managers offer hospitality ministries such as meal vouchers and assistance with securing housing for visitors. Chaplain managers also provide spiritual and emotional support during crisis events and end-of-life situations and serve as advance care planning consultants for each medical center. Finally, chaplain managers oversee religious programming such as weekly chapel services and serve as liaisons between the medical center and community clergy. The chaplain “hat” of the chaplain manager role functions like a chaplain in other healthcare settings. What is particularly unique about the way this role is carried out is in its multiplicity that allows the chaplain to function in traditional roles as well as offering a supportive role that continues beyond one’s hospital admission.

While chaplains have supported staff members throughout the medical center’s history, intentional efforts to support staff through a chaplain role created specifically for them began in 2012 through the imagination of Chaplain Jay Foster. While the Chaplain Manager for Staff Support role continues to thrive at Wake Forest Baptist Medical Center, this intentional support is offered by chaplain managers at network hospitals through the work of Code Lavender²⁰ and the Employee Emergency Fund. Code

²⁰ This model of staff support was originally called “Code C.A.R.E.” When Atrium Health Wake Forest Baptist merged with Atrium Health, Code C.A.R.E. adopt the brand “Code Lavender,” Atrium Health’s staff support program.

Lavender is a staff support program that encompass spiritual care interventions such as blessing of the hands ceremonies, workplace violence supportive engagement, and intensive interventions such as critical incident stress debriefings. Chaplain managers also serve as bridges to the medical center's Employee Assistance Program (EAP), a benefit offer through human resources.

Although chaplain managers at the satellite campuses are the only full-time spiritual care practitioners, each campus has on-call contract chaplains called chaplain associates that report to chaplain managers. As contract employees, chaplain associates have a unit of CPE and are either pursuing graduate theological studies or have completed a Master of Divinity or an equivalent degree. Although they are not physically present at each medical center for a 24-hour shift, they are on call and are expected to respond to emergency calls within 45 minutes of receiving the referral.

Although students do not serve satellite campuses as their primary ministry site, chaplain managers partner with our CPE faculty to educate students through didactics, mock board certification committees, mid-year consultations, network campus tours, and as fellowship mentors. At times, recent graduates of the CPE program serve as chaplain associates until other full-time or part-time opportunities arise. For students planning to serve in community hospital locations, the work of chaplain managers provides a snapshot of chaplaincy that is connected to but separate from an academic trauma center with a CPE program.

Community Engagement

Chaplain managers also oversee the community engagement department of FaithHealth in each hospital community, forming and sustaining relational networks of trust to create healthy communities. Specifically, chaplain managers have a caseload of patients they follow to ensure access to healthy and sustainable food, transportation resources, adequate housing, pharmacy access and education, and connection to a primary care office. To accomplish this work, chaplain managers build networks of volunteers in faith communities and broker relationships with nonprofit entities to ensure community members do not fall through the cracks of traditional social service avenues of support. FaithHealth connectors, part-time contract employees of the medical center, work with chaplain managers and faith community volunteers to coordinate supportive care efforts and extent the FaithHealth network.²¹ While there are many parallels between FaithHealth community engagement and traditional clinical social work, two key differences serve to amplify the social work's reach by intentionally forming relationships that extends beyond the medical center visit and the emphasis on supporting individuals who do not qualify for pre-existing models of support within a community.

Maya's story illustrates the relational work of community engagement quite well.²² Her son, George, was a pulmonary patient of Brenner Children's Hospital and had

²¹ FaithHealth connectors and trusted individuals that work within community in addition to their work with FaithHealth. For instance, the two current connectors that work with Davie Medical Center and serve Davie County serve two not-for-profit entities within the community. The first is a United Methodist pastor who grew up in Davie County and has relational capital with local pastors, local government leadership, and various avenues of connection with the neighbors served through FaithHealth. This connector is also the founder of a not-for-profit ministry hub in Cooleemee, the county's most impoverished and isolated area. The second connector works for the county's only homeless ministry and has a long history with Davie County as a housing specialist. While both connectors have diverse backgrounds and skillsets, both are trusted members of the community who value equity and inclusion of all community members and their access to healthcare.

²² To protect the identity of the patient, "Maya" is a pseudonym.

a condition that would require an in-home machine to support his lung function.²³

Unfortunately, North Carolina Medicaid would only pay for the in-home equipment if the residence had a standby generator. Care coordination was able to find a grant through the energy co-op to pay for the generator, but the grant required that the standby generator be covered by a permanent structure separate from the individual's home. Maya, who rented a single-wide mobile home in Davie County and had all but quit her job to care for George, did not have means to build a permanent structure and could not find grants to support this effort.

Care coordination turned to FaithHealth to see how this system of support might help this family. Fortunately, our connector at that time was a retired minister who had served at a large, multi-site church. Within hours, he had contacted the church's mission team and received a verbal commitment to cover all the labor for constructing the building. Another member of that church worked at a local hardware store and was able to secure a donation of materials that would fully support this project. George was home with his mom within two weeks of the initial call to FaithHealth.

As with Maya's example, the work of FaithHealth community engagement is multifaceted and involves a network of support. Essentially, there were no resources to satisfy the grant's requirement without a budget, but the relational work of faith and support enabled this dream to become a reality. Chaplain managers serve as coordinators of these webs of trust and connectors are orchestrators at matching community members' needs with available resources. Referrals for FaithHealth services are generally made by care coordinators who are connected to the chaplain managers. Referrals are then shared

²³ "George" is a pseudonym. Brenner Children's Hospital is connected to Atrium Health Wake Forest Baptist.

between chaplain managers and connectors with chaplain managers closing the care loop once needs are satisfied.

CareNet Counseling

There are CareNet Counseling offices in Davidson, Davie, and Wilkes Counties, but only Davie has a CareNet office inside of the medical center. As a provisionally licensed counselor in North Carolina, my work as a chaplain manager includes traditional counseling services and integrated behavioral health. I maintain a small caseload of clients that I see as traditional care clients out of my office within the medical center and each client is seen free of charge. I also provide behavioral health support as an integrated care clinician in our cardiac rehabilitation program and other ambulatory clinical areas. While the beauty of the chaplain manager role is its integration of bio-psycho-social-spiritual self, there is intentionality about nuancing my role, goal and context when serving specially in the role of therapist.²⁴ Given the increased need for mental health support in 2022 and the lack of behaviorists in our region, I feel this is an important part of my role that extends the FaithHealth work of caring for the most vulnerable to behavioral health.

Perhaps I see this connection the clearest as a therapist when I am outside of the traditional “counseling hour.” The intersection of bio-psycho-social-spiritual support seems most prevalent when educating groups about wellness, emotional regulation, the role of faith and faith communities in caring for those mentally ill, or creatively forming

²⁴ As a therapist, the contract I have with clients is different from the relationship of support I have as a chaplain or as a community health worker. Since my counseling work is held to a few hours a week, I am clear with staff and patients when I am contracting as a therapist and when I am offering support in another role.

connections with vulnerable populations through programs such as Healthy Farmer. I present regularly to faith communities about the role of faith communities in offering places of sanctuary and to programs such as Stephen's Ministries about spiritual and emotional support with congregants. I also feel that I make a significant impact with groups of people, such as those in cardiac rehabilitation, when I teach patients or community members about self-care, wellness, stress management, mindfulness, and emotional regulation.

The most recent programmatic intersection of these three roles is through the Healthy Farmer program, an initiative of NC Agromedicine Institution. Through grant support from NC Tobacco Trust and NCDA, the NC Agromedicine Institute recognized the nuance of farmer and rancher stress and relatively high rates of depression, self-harm and substance abuse. As a result, the organization partnered with CareNet Counseling for a three-fold endeavor: (1) educate NC Cooperative Extension agents about signs of mental and emotional distress and educate CareNet therapist on the unique stressors of farmers and ranchers; (2) fund six counseling sessions at CareNet Counseling centers for up to 100 farmers and ranchers from farmer owner to seasonal migrant workers and their families; and, (3) hire six FaithHealth connectors to support six rural agricultural communities across North Carolina to identify local resources and connect additional partners to this work. If the program can show efficacy, the NC Agricultural Institute should be able to secure additional funding to increase the program's impact next year. This program and others that blend population health and behavioral health seem to impact a larger portion of the population and thus offers care to more individuals that need support.

Chaplain Manager as Organizational Leader

In naming the role of chaplains within organizational culture, Nathan H. White says, “Those within organizations are responsible to shape them for their betterment, using the inherent power and stability of the organization to help and protect, rather than to marginalize or exploit vulnerable and diverse populations. Chaplains can and should play a vital role in this effort by becoming catalysts for beneficial change.”²⁵ In addition to the primary functions of chaplain managers as practitioners, they also serve as organizational leaders, both in the local context of their medical centers and in system-level initiatives. While chaplain managers are clinical in nature, they also fall within the managerial structure of Atrium Health Wake Forest Baptist as a system. Chaplain managers are both people leaders and programmatic leaders. One such program is the religious programming of the chapel and the meditation offerings of the serenity room.

Chapel and Serenity Room

As an extension of our division’s ministry, chaplain managers oversee religious program and spiritual care offerings within the medical center’s serenity room and chapel. At Davie Medical Center, these spaces are located across the hallway from one another between the inpatient medical unit and the emergency department. The serenity room is a converted consultation room that includes a massage chair, meditation resources, walls of encouragement and a table for healing touch. This room is for staff members only and it is available to staff members in fifteen-minute increments throughout their shift.

²⁵ White, “Facilitating Resilience,” 201.

Davie Medical Center's chapel was added as part of the inpatient addition in 2017. The space is filled with abstract art on both walls and has a window looking out at the forest as the front wall. While the artwork and architecture of the chapel are modern, the pews, alter, kneelers and lectern are more traditionally stained oak. The furniture was refurbished during construction from the former chapel at Davie County's previous hospital in the county seat of Mocksville. Since some of our staff transitioned from that hospital to Davie Medical Center upon completion, it is a nice testimony to the spiritual care offered to patients, their families, and staff members within the former and current hospitals of Davie County. The lack of traditional religious symbols conveys the interfaith element of a chapel and the abstract art and clear-glassed window behind the alter invites individuals into a contemplative and reflective space. The centrality of the prayer book also indicates that prayer and reflection are primary uses of the chapel space.

Since March 2020, a new niche for the chapel emerged because of Covid-19 and subsequent visitor restrictions. The chapel became a consult room for our medical team to have conversations with family members outside of the visitor restrictions of the unit. It also served as a place for families to video call their loved one in the hospital and pray with them from the chapel. This new ministry of the chapel offered intercession between the Holy, families, and patients by offering holy ground amid anxiousness and uncertainty.

Health System Committees

Chaplain managers serve on a variety of health system committees that have localized subcommittees on each campus. These committees include chairing the

bioethics subcommittee, chairing the DAISY and BEE Awards committee,²⁶ participating in the patient and family centered care committee, and co-chairs of the workplace violence committee. While chaplains have traditionally participated on bioethics committees and in some form of patient and family centered care committees, chaplaincy involvement in workplace violence committee is a recent phenomenon within our system.

Hospital-Specific Committees

At Davie Medical Center, the chaplain manager co-chairs the workplace violence committee in addition to participating in the system level committee. Chaplain managers offer individual support and group debriefings to staff member affected by workplace violence and serve on the BERT team, an acronym that represents the Behavioral Escalation Response Team. This group, comprised of a nurse leader, the chaplain manager, and a security officer, meets with patients who exhibit aggressive behavior in an attempt to deescalate the situation before violence of any type occurs. Recently, chaplain managers have served as educators of escalation techniques for other departments within the medical center. Chaplain managers also serve as members of the emergency management team, assisting with the management of supplies and staffing during emergencies as well as monitoring the well-being of those involved in emergency or disaster situations.

Davie Medical Center also champions the patient and family centered care model for our health system. As part of this emphasis, the chaplain manager participates in a

²⁶ The DAISY Award is a nation recognition program for extraordinary nurses. DAISY is an acronym for Diseases Attacking the Immune System. The BEE Award is a regional recognition of certified nursing assistants (CNAs).

program called “Welcome to Davie” and a full-day training on patient and family centered care. Welcome to Davie is an on-site orientation to the culture and resources of the medical center beyond the system-level orientation program. The chaplain manager explains the role of the chaplain, resources for support such as the chapel, the serenity room and the fitness center, and programs of support such as the employee assistance program (EAP) and the emergency financial fund (EEF). The chaplain manager participates in the full-day patient and family centered care training by facilitating an empathy curriculum that include didactics, role play, and a poverty simulator. Another element of patient and family center care that chaplain managers co-lead with the manager of patient relations is a program call “Leadership Connect.” This program aims to create and sustain community among the leadership team by offering quarterly by offering educational events, service projects, and fun outings. For instance, a few Leadership Connect offerings include a four-session workshop on the Myers-Briggs Type Indicator (MBTI), the enneagram, and emotional intelligence, a Tuesday afternoon bowling outing, and a painting project for a transitional house for Family Promise of Davie County.

As previously mentioned, chaplain managers are leaders of people in addition programmatic leaders. In other words, they manage people in a variety of roles in addition to various programs. Chaplain managers at each campus are responsible for the FaithHealth connectors that serve within the counties of each medical center and serve as the managers of the chaplain associates that provide on-call coverage. Connectors and chaplain associates meet monthly in separate meetings but also meet with chaplain managers for one-on-one meetings, when necessary. Chaplain managers are also

responsible for ensuring chaplain managers and connectors are up-to-date on medical center educational requirements and employee health mandates and are responsible for scheduling coverage for each campus.

Chaplain managers serve as leaders and champions of diversity, equity and inclusion on their respective campuses. Given the demographics of the counties that house network hospital and the treatment of person of color by our communities and institution, it is important that chaplain manager offer a prophetic voice of truth to name white culture. Su Yon Pak states that “understanding the persistent power of a white racial frame that is embedded...in the society is key to recognizing how this frame shapes, validates and protects the racialized hierarchy of power.”²⁷ As chaplain managers, we must attend to the embedded frame with “interpersonal, small-group, and institutional” levels of society by taking responsibility for our own journey of awareness, how discrimination and dominant culture show up within the medical center, and how racism and injustice undergird community engagement.

Chaplain Manager as Community Leader

Describing the intersection of individualized spiritual care and social justice, Miller-McLemore writes: “This mythos [interconnectivity of selfhood] and the theology connected to it have funded a new approach in pastoral theology. More specifically, this means, for example, that public policy issues that determine the health of the human web

²⁷ Su Yon Pak, “Through a Multi-frame Lens: Surviving, Thriving, and Leading Organizations,” in *Chaplaincy and Spiritual Care in the Twenty-First Century*, Ed. Wendy Cadge and Shelly Rambo (Chapel Hill: The University of North Carolina Press, 2022), 233.

are as important as issues of individual emotional well-being.”²⁸ Richard Coble and Mychal Springer take this connection further, stating, “For chaplains, systemic justice and spiritual caregiving are linked because they do not meet their care receivers in a vacuum, without context or power dynamics.”²⁹ In addition to serving as spiritual care practitioners and leaders within the organization, chaplain managers are leaders within their respective communities. While community leadership is different than the specific functions of the department of FaithHealth community engagement, much of chaplain managers’ community leadership focus on the systemic social and health issues affecting the most vulnerable members of a community. The needs and community leadership opportunities in each community are different, but the involvement of chaplain managers in leadership is common throughout the Atrium Health Wake Forest Baptist system.

Community Health Needs Assessments (CHNA)

As part of the *Affordable Care Act*, nonprofit hospitals are required to conduct a *Community Health Needs Assessment (CHNA)* and a *CHNA Implementation Strategy* every three years. The CHNA report is the summation of county demographics, primary data from individuals utilizing health services within the community or other health experts such as a representative from the county’s health department, a commitment to health strategies to accomplish throughout the preceding three-year cycle, and a summation of activity and accomplishments for the previous cycle. The implementation

²⁸ Bonnie J. Miller-McLemore, “The Living Human Web,” in *Images of Pastoral Care: Classic Readings*, ed. Robert C. Dykstra (St. Louis: Chalice Press, 2005), 42-43.

²⁹ Richard Coble and Mychal Springer, “Interpersonal Competence in Contextualizing Power Dynamics in Socially Just Spiritual Care,” in *Chaplaincy and Spiritual Care in the Twenty-First Century*, Ed. Wendy Cadge and Shelly Rambo (Chapel Hill: The University of North Carolina Press, 2022), 172.

strategy is a detailed plan of how the medical center will address these strategies with measurable outcomes.

The chaplain managers at Davie Medical Center and Lexington Medical Center serve as the writers and organizers of the CHNA and implementation strategy for each campus. As part of this role, chaplain managers work closely with their respective health department representatives to ensure community members' voices are heard and accounted for in the county's health assessment and the medical center's CHNA. This work also requires a strong, collaborative relationship with each hospital's executive team as financial resources and commitments are often key components of addressing health disparities. In writing these documents, chaplain managers are also able to creatively plan for how FaithHealth's involvement can strengthen the medical centers' commitment to underserved populations.³⁰

Miller-McLemore states that "personal problems are always necessarily situation with the interlocking, continually evolving threads of which reality is woven, and they can be understood in no other way."³¹ The CHNA process offers chaplain managers and platform to integrate clinical healthcare with community needs, reminding themselves

³⁰ Chaplain managers are able to constructively place themselves into the work stream and executive structure of the CHNA by serving as primary writers. This responsibility also amplifies the importance of hospital systems reestablishing themselves as hubs of community wellness rather than a business with arms of community engagement.

³¹ Bonnie J. Miller-McLemore, "The Living Human Web: A Twenty-Five Year Retrospective," *Pastoral Psychology* 67, no.3 (2018), 313.

and their clinical colleagues of the treads of health and “dis-ease”³² that exist in the gaps between “inside the walls” and “outside the walls” of healthcare systems.

Nonprofit Board Leadership and Community Initiatives

Chaplain managers hold key roles within nonprofit entities and other community initiatives within their respective counties. In Davie County, I serve on the boards of the United Way of Davie County and Family Promise of Davie County and I am part of an aging taskforce and a domestic violence taskforce. Being involved in community initiative extends the mission of the hospital beyond its wall to impact the broader community. Similar to how the first chaplain of North Carolina Baptist Hospital attended community events and fundraisers with the hospital president, chaplain managers represent the medical center as agents of health in partnership with the communities the medical centers serve.

Coordination with Area Clergy

Chaplain managers coordinate the medical centers’ connections with area clergy within each satellite campus community. Such coordination took the form of sharing information about hospital visitation policy changes and visiting COVID-19-positive patients during peaks of COVID-19 and serving as contact for local faith community wishing to honor and celebrate healthcare workers during the pandemic as well. Additionally, chaplain managers partner with local clergy members in meeting social

³² James k. Bruckner, *Healthy Human Life: A Biblical Witness* (Eugene: Cascade Books, 2012), 212.

needs within each community, such as promoting a faith community's clothing closet during the winter months or engaging hospital staff in toy drives during the holidays.

Boundary Leadership

In *Boundary Leaders: Leadership Skills for People of Faith*, Gunderson describes the necessity of leaders working on the periphery of their profession to engage in globally good practice.³³ As the Vice President of the FH division, Gunderson weaves boundary leadership into the tapestry of our organizational identity. *Boundary Leaders* is influenced by his work at Emory University and The Carter Center, so HIV/AIDs, substance abuse, poverty and racism as witnessed and experienced in Atlanta serve as primary movers for this work. Gunderson is an ordained UMC minister and widely-acclaimed public health authority that urges the church to broaden its vision of engagement with systemic issues that impact those most vulnerable in community. The nuanced use of boundaries in this book speaks "...not to where things separate, but the edge of where things join."³⁴ Boundary leadership is a call to reframe boundaries as relationships to engage rather than lanes to maintain.

According to Gunderson, boundary leaders "...align the assets of community with the most relevant science and most mature faith."³⁵ This form of leadership is always looking for areas of community that choose life and such leaders seek to emulate this life-giving energy at a broader community scope.³⁶ While such leaders often work within

³⁴ Gary Gunderson, *Boundary Leaders: Leadership Skills for People of Faith* (Minneapolis: Fortress Press, 2004), loc. 131 of 1763.

³⁵ *Ibid.*, loc. 112 of 1763.

³⁶ *Ibid.*, loc. 83 of 1763.

organizations that encourage leadership silos, Gunderson suggests that boundary leaders are loyal to their organization only to “...the extent they are part of the pattern of emergent life.”³⁷ Such emergent life resides in boundary zones where silos are less rigid and more open to community partnerships.³⁸ According to Gunderson, boundary zones “...make possible a social architecture in which new relationships are possible, sustainable, and even powerful.”³⁹

To illustrate boundary leadership as a model, Gunderson share a time when he observed Mike Heisler, an intensivist in the medical intensive care unit at Grady Health in Atlanta. As Gunderson observed rounds with Heisler on his unit, he visits patients with advanced asthma, pneumonia, hypertension, and a drug overdose.⁴⁰ While epidemiologists and pathologists could certainly identify lifelong smoking, obesity, and cocaine addiction as precipitating factors in the patients’ respective lifestyles, they would not typically identify these symptoms as a “deep failure of many other systems.”⁴¹ Boundary leaders name broken systems and work with strategic community partners in boundary zones to proactively rectify lifeless systems. Gunderson encourages faith leaders to consider how they contribute tangibly and spiritually to live-giving initiatives.

Perhaps this is seen most clearly in the interpretation of boundary as a place of possibility rather than a territorial line. It is a healing idea to focus on inter-agency and

³⁷ Gunderson, *Boundary Leaders*, loc. 120 of 1763.

³⁸ *Ibid.*, loc. 151 of 1763.

³⁹ Gunderson, *Boundary Leaders*, loc. 1225 of 1763.

⁴⁰ *Ibid.*, loc. 66 of 1763.

⁴¹ *Ibid.*, loc. 66 of 1763.

interpersonal relationships fostering substantial change rather than such change occurring through the work of one individual or agency. I also appreciate the connection highlighted between public health and the role of faith-based organizations. In my experience, these entities are often less connected pragmatically and tend to lean toward reactive support through community presence. Gunderson lives out the best qualities of his work in his leadership at Atrium Health Wake Forest Baptist. His employees are encouraged to think outside of our traditional roles and imagine ways to better serve those most vulnerable in our community. Our team has a strong balance of leaders and managers who help to develop praxis out of a model so theoretically-oriented.

The concept of boundary leaders undergirds the role of chaplain managers and the community organizing work of their ministry. The chaplain manager model appreciates the multi-faceted role of chaplain, community health worker and counseling and the boundary between being in the hospital versus extending beyond its walls as opportunities for ministry rather than territorial line. There are also limitations to this model in addition to its many strengths. For instance, this model muddies professional identity and chaplain managers must be aware of the contracts they are creating with care receivers. Second, such innovation is daunting and can tempt chaplain managers to sacrifice self-care in pursuit of leadership and care. Other challenges will surface throughout the coming chapters.

Conclusion

The role and function of chaplain managers are complex, including traditional practitioner models that intersect collaboratively, medical center leadership, and leadership within the broader communities of each medical center. Chaplain managers

are boundary leaders that welcome integration and inclusion of various roles and identities within the ministry model. The uniqueness of the FaithHealth chaplain manager model is the freedom and commission to work presently in the intersubjective space between caregiver and care receiver in whatever part of the human web needs accompaniment. Chaplain managers continue to offer care to individuals and their families, but they are also emboldened to “identify and join with others who are working in the community to change the conditions that perpetuate suffering.”⁴² The following chapter explores how this integrative model provided the adaptation and flexibility need to minister effectively during the coronavirus pandemic.

⁴² Pamela Cooper-White, *Shared Wisdom*, 125-126.

Chapter Three

Chaplain Managers and COVID-19 Pandemic

The coronavirus pandemic has challenged nearly every aspect of life in the United States since early 2020. In addition to the science behind discovering the virus, testing, creating a vaccine, and medication relief, medical centers were challenged with the same personnel restraints and supply issues as other businesses globally. While most, if not all, were impacted by the pandemic, the community's most vulnerable neighbors were perhaps hit the hardest by the virus and subsequent societal ramifications.

The networks of trusted relationships formed through the FaithHealth chaplain manager role proved vital throughout the pandemic. From caring for patients and staff members to creating community testing sites in resourced challenged communities, the freeing structure of the FaithHealth chaplain manager role provided opportunities for chaplain managers to minister to the needs of each community. This chapter will explore the impact of COVID-19 in the communities served by Atrium Health Wake Forest Baptist, the challenges and growth opportunities discovered through the pandemic, and glimpses of hope in the resilience of the human spirit.

Impact

There were 331,234 confirmed cases of COVID-19 and 9,458 COVID-related deaths within the United States on April 5, 2020.¹ North Carolina alone accounted for

¹ "Coronavirus COVID-19 Global Cases by the Center for Systems Science and Engineering (CSSE) at John Hopkins University," John Hopkins University, accessed April 5, 2020, <https://coronavirus.jhu.edu/map.html>.

2,646 of those total cases and 37 individuals were lost to COVID-19 at that point.² North Carolina instated the practice of social distancing in hopes of “flattening the curve” and Governor Roy Cooper’s Shelter in Place initiative had been in place since March 30, 2020. Businesses deemed non-essential are encouraged to find alternative ways to continue their work, schools are closed, faith communities are gathering virtually, and hospital employees lack personal protective equipment (PPE) to carry out their caregiving adequately and safely. Our area of greater Winston-Salem had yet to feel the overburdening of the health system the same way as Mecklenburg, Durham, and Wake counties.

Our management team had worked tirelessly since the first of March to prepare for the worst-case scenarios. They knew an exact count of surgical and N-95 masks at each of our hospitals, had a plan for repurposing surgical suites for intensive care rooms with ventilators, our triage tent was stocked in the event it needs to be activated, and we had trained our staff to don and doff personal protective equipment (PPE) in ways that lessens the potential of contracting the newly discovered virus.

The reality was, however, that there is an unsettling in the air that felt like preparing for a hurricane without a map or a radar. Our staff were confident they can serve our community well, but they knew of the shortages of goggles, masks, and gloves to protect them from the ones they are serving. They knew we have a finite number of ventilators and negative pressure rooms in North Carolina and across the country. They also knew stories of young emergency department (ED) physicians and nurses without

² “Coronavirus.”

known comorbidities losing their lives caring for their neighbor. And, they knew that the selflessness of their work is remarkable, but also increased the threat of their families contracting the virus. Healthcare workers, including chaplains, are essential staff and no one knew with certainty the long-term ramifications of that job classification.

As of June 5, 2022, there have been 84.5 million confirmed cases of COVID-19 in the United States and over one million deaths.³ It has been more than two and a half years since we lived in a world free of the coronavirus pandemic. Despite the surfacing of multiple variants and free, available vaccines, COVID-19 is perhaps as taboo as religion and politics when conversation stirs among a group of people. Unsurprising, those taboo topics of religion and politics perhaps fueled the fire of fear, skepticism and selfishness greater than any other modes or sources of information. While social distancing and mandated mask wearing have subsided for now, the effects of COVID-19 – namely, loss, fear, scarcity, drastic economic shifts, workplace transitions, and uncertainty – continue to take its toll locally and nationally.

As the chaplain manager, the early days of COVID-19 involved working primarily with staff members and medical providers around wellness and emotional regulation. Much of my work mirrored the work of chaplains and counselors across the country because the initial wave of acute illness, anxiousness, and supply chain impact necessitated an emphasis on traditional spiritual care work. I provided virtual and telephonic pastoral care with patients and their families in our hospital as hospital visitation was limited with few exceptions and we needed to limit PPE use as much as

³ “COVID Data Tracker: Daily Updates for the United States,” Center for Disease Control and Prevention, accessed June 5, 2022, <https://covid.cdc.gov/covid-data-tracker/#datatracker-home>.

possible. Some of my work also included educating clergy and local congregations on medical center access and responsible social distancing. I was invited by our hospital administrators to offer daily prayers and meditations for our staff members and this interfaith offering were well received by most in our medical center. Our hope in doing so was for teammates to have a centering moment to connect their work to something bigger than themselves and know that others recognized the selflessness of their work.

My work as a chaplain manager has changed drastically since the onset. Visitors for much of 2020-2021 were not allowed in any Atrium Health Wake Forest Baptist facility with a few exceptions for health care decision makers and those assisting with mobility. Patients in our labor and delivery unit were allowed only one visitor throughout their hospitalization and those who are passing away could only have two family members by their sides. Feelings of isolation and fear were common experiences among the patients I visit regularly and patients explored alternative ways of connecting with their friends and family members. There also seemed to be apprehension when providers and clinical staff enter a patient's room. As one elderly patient stated to me, "I am more fearful of what I could get here than I am taking my chances [with pneumonia] at home." Our patients were greeted with their very own masks as soon as they arrive and they never saw the uncovered face of their caregivers throughout their hospital visit.

Compassion Fatigue and Burnout

Our staff members were exhausted and inundated with COVID-19 information both at home and at work. Some of our staff members recognize their previously experienced emotional strains of H1N1 and Ebola. Others have never experienced anything like this magnitude professionally, including their chaplain. I reminded staff

members to utilize self-care practices, to get outside and enjoy time with their families, to pray and breathe, and to trust they are equipped to offer their everyday compassionate care to others regardless of their impact. Each new rule-out COVID-19 case and the four days it took to receive conclusive lab reports added new stress to the environment.

To illustrate this tension, I met with Kim as she was having a panic attack in the break room.⁴ Kim has been a nurse in our medical inpatient unit since 2017, but was a nurse manager at another North Carolina academic hospital for sixteen years prior to joining Atrium Health Wake Forest Baptist. Kim transitioned from management due to several life changes: her husband asked for a divorce, she became the sole caregiver of her mother with dementia after her father died, and she has primary custody of her middle and high school children. After helping Kim emotionally regulate and establish presence in the room, she told me what she thought initiated her panic attack that morning. She was a nurse manager during the Ebola outbreak and recognized that fear as congruent with her experience of a rule-out COVID-19 patient that morning. She had cared for this patient for a twelve-hour shift unmasked the day before his COVID-19 symptoms became concerning. She now worried she would be a vector for the virus' possible spread to her mother and children as well as other patients and staff members she encountered throughout the day.

Kim and other healthcare providers knew the landscape of the illness as it has unfolded in China, Italy, Seattle, and New York City. They heard the daily inventories of N-95 and surgical masks on site, the precious available ventilators within our system, and

⁴ Kim is a fictitious name used to protect the identity of the staff member.

the shortage of hand sanitizer across the country. They saw the erected triage tent outside the emergency department and they worry about the waves of patients that could show up any day. They knew the end was not in sight and knew that they will soon resort to the same home-sewn masks being used in other areas of the United States.

As with much of my ministry, silence and being a non-anxious presence are two of my strongest assets as a communicator. Whether I am in a planning meeting for COVID-19 or charting at the nurses' station, I am intentionally calm and careful with my responses in stressful encounters. Life right now in the medical center is full of words. National and local news fill the halls of the medical center through the blaring of televisions and the whispers of fear to another. Most that ask me about a frame for suffering and hope theologically want me to present such discourse in a bulleted one-page list with an abstract at the top. Unfortunately, theological conversations surrounding suffering and hope during COVID-19 require much more than that. To quote James K. A. Smith in *How (Not) to be Secular*, "We don't believe instead of doubting; we believe while doubting. We're all Thomas' now."⁵ In many ways my work is to help staff members sit in the uncomfortable space between believing and doubting as COVID-19 continues to spread across the globe.

In 2020-2022, the referrals I sent for staff members to visit our Employee Assistance Program (EAP) for counseling increased four times the number of referrals I made in 2019. Our staff members are exhausted and the moral injury they are experiencing is taking its toll on their professional and personal lives. Many report

⁵ James K. A. Smith, *How (Not) to be Secular: Reading Charles Taylor* (Grand Rapids: William B. Eerdmans Publishing Company, 2014), 4.

insomnia and heightened anxiety. Others share that they are struggling with alcohol and other addictions previously managed well with coping strategies. I have worked with three individuals who experienced panic attacks at work and needed help emotionally regulating.

Additionally, many of our staff member were sent home on unpaid leave because elective surgeries and procedures were canceled. The medical center worked to cross train staff to work in the emergency department, but there were staff members sent home without any assurance as to when surgeries would resume. In 2022, our concern is now having enough staff in the medical center to carry out our mission. As in other professions, including the pulpit, shifts in the workforce have the potential to influence the span of our medical center's impact on the community.

Moral Injury

While COVID-19 numbers are currently low in our area, the consensus of most behavioral health professionals, however, is that we are merely entering a new phase of the pandemic. Instead of a crisis of biological proportions, the new crisis is one of mental health and the toll of months of isolation, fear, uncertainty, grief, and a spectrum of other emotions is a traumatic reality. In addition to the ongoing, systemic trauma of the pandemic, many healthcare professionals are suffering from moral injury, too.

While our medical center did not reach the triage level of choosing which individuals would and would not receive life-sustaining measures such as ventilation, our bioethics team mapped out how we would engage this triage process if necessary. Our teams did, however, ration personal protective equipment (PPE), triage non-life-

threatening, but serious, conditions to free up intensive care and operating room availability, and enforce a strict no-visitor policy that at times was quite heart breaking.

As I think about the moral distress and injury caused by many of these decisions, three staff members come to mind. The first is the emergency department's nurse manager who felt she was betraying her staff by sending them into COVID positive room without the PPE necessary to keep them safe. Nearly a year later, she shares with me her night terrors of seeing the faces of her staff members' kids and remembering her management duty of keeping her employees safe. While she did the best she could to protect her staff, many of them contracted the virus and transmitted it to their families. The second is a respiratory therapist who missed the arrival of his first child out of fear of sharing the virus with his pregnant spouse. Their child was two weeks old before he was able to hold her because he wanted to quarantine before going home. While he was glad to finally hold her, he feels like he, in some ways, transformed into his workaholic father by missing his daughter's birth. The last was threats made toward a security guard and me by a family member of a dying patient with COVID-19 who could not understand why he could not hold her hand rather than our iPad.⁶ Unfortunately, the patient already had the one family member she was able to have with her in her room. Our commitment to familial sacredness of that moment was institutionalized in the cold screen of a FaceTime call.

Some of our staff members continue to be traumatized. While it is certainly less acute than it was in 2020, some now carry with them moral injury and their healthy or

⁶ As further evidence of the mental health crisis, our workplace violence incidents are at an all-time high across all Atrium Health Wake Forest Baptist medical centers.

unhealthy coping mechanisms in addition to their ongoing work with COVID-positive patients. Most of my work with employees involved breathing techniques and other mindfulness exercises, encouraging self-care, accompanying and bearing witness to suffering, offering blessings through ritual, and praying. Perhaps these are the best gifts to offer those still in the foxholes of COVID-19.

Adaptive Leadership

The challenges produce by COVID-19 required leaders to lead with flexibility and a vision that accounted for the unknown and unexpected. Such a challenging environment required the adoption of adaptive leadership. According to Heifetz, Grashow and Linsky in *The Practice of Adaptive Leadership: Tools and Tactics for Changing Your Organization and the World*, adaptive leadership is “the practice of mobilizing people to tackle touch challenges and thrive.”⁷ The authors suggest six tenets of adaptive leadership theory: (1) such leadership is change-specific and capacity-oriented; (2) success unfolds the past rather than denying it; (3) experimentation drives organizational adaptation; (4) diversity is a core foundational element of adaptation; (5) further adaptations significantly transforms an organization’s DNA; and (6) such a process of adaptation takes time.⁸ Adaptive leadership begins by mobilizing individuals to meet immediate challenges which carries over to “other culture-shaping” energies that foster adaptive capacity.⁹

⁷ Ronald Heifetz, Alexander Grashow, and Marty Linsky, *The Practice of Adaptive Leadership: Tools and Tactics for Changing Your Organization and the World* (Boston: Harvard Business Press, 2009), 14.

⁸ Ibid., 14-16.

⁹ Ibid., 17.

The authors state that “no one who tries to name or address the dysfunction in an organization will be popular.”¹⁰ Often dysfunction takes the form of technical problem and adaptive challenges and these forms of dysfunction are often misidentified. Technical problems typically have known solutions, whereas adaptive challenges can be solved only through modifications in “people’s priorities, beliefs, habits, and loyalties.”¹¹ They also discuss the distinguishing characteristics of leadership and authority. According to the authors, authority is granted to others with the assumption that leaders conform to the organizational structure and provide problem-solving skills, but adaptive leaders challenge the expectations of the organizational system to promote change. The authors quickly point out that “exercising adaptive leadership is dangerous.”¹² Since such adaptation produces disequilibrium, adaptive leaders need to self-manage their own presence in the environment and help others tolerate the discomfort of disequilibrium.¹³ Once in the productive zone of disequilibrium, adaptive leaders begin a cycle of observing, interpreting, and intervening within the challenges at hand.¹⁴

Fortunately for those served, members of the division of FaithHealth function well in stressful situations that require a tolerance of discomfort. Part of this is because practitioners within the FH division work in professions where disequilibrium is routine, at least in the lives of those served. Perhaps FaithHealth also functioned well throughout

¹⁰ Heifetz, Grashow, and Linsky, *The Practice of Adaptive Leadership*, 17.

¹¹ *Ibid.*, 19.

¹² *Ibid.*

¹³ *Ibid.*, 29.

¹⁴ *Ibid.*, 32.

the pandemic because the division's leadership engaged in adaptive practices, especially the tenets of experimentation and being change-specific and capacity-oriented. The leaders of the FH division encourage collaboration and experimentation in caring for patients, clients and community members, realizing that normal operating functions would not adequately address evolving pandemic needs. Furthermore, our leaders encouraged us to realistically reimagine our work within the confines of our own capacity to care for others.

Technology

Ministry to patients in the medical center setting has embraced technology by necessity during the pandemic. Fortunately, we have video conferencing capabilities with those admitted to our inpatient unit, so I check in on patients virtually each day. Many of them spend hours watching the news or worrying about their family members in their respective communities, so my work focuses primarily on listening to concerns and offering a non-anxious presence during uncertainty. Until recently, all of my counseling sessions were held virtually on a secure, HIPPA-approved platform. My work was completely virtual with patients in the early days of the pandemic as a way of saving vital PPE throughout this crisis. Thankfully, our supplies increased and I could visit patients in person, but not without donning the vestments of a mask, goggles, gloves, gowns, and at times, a PAPR.

Communication tools throughout COVID-19 have been instrumental in staying connected with updates. We regularly used Zoom and WebEx for staff meetings and patient care encounters. Our department has been historically hesitant to fold new technology into the tapestry of our work, but COVID-19 has required us to do so quickly.

We used Microsoft Teams for all COVID-related departmental communication and using messaging applications such as Slack and GroupMe for quick communication that does not include private information. We are learning that we are more efficient with our communication than many of our in-person meetings and that technology can help us feel more connected in our fast-paced work.

In addition to patient care within the medical center, technology provided a safe means to seeing clients during the pandemic. I was hesitant at first to engage clients virtually, but I found that many of my clients who struggled with depression and anxiety preferred meeting remotely from the security of their home. Technology also helps some of my clients who cannot afford the transportation to regularly travel to the medical center for sessions. While I imagine telehealth scaling back in the coming year, I imagine it continuing to serve the clients I see regularly.

I think we do, however, miss an element of connectedness through virtual communication. I do not think this is the way of the future for pastoral care and counseling outside the limitations of a pandemic, but I do think it is necessary and relevant for the task-oriented work of our team. Using platforms that allow individuals to read messages at their own convenience is one of the ways messages are clearly communicated across our multi-hospital system. In *Networked Theology*, Campbell and Garner encourage us to think about “where is my neighbor?” in addition to “who is my neighbor?”¹⁵ In an age of working-from-home and social distancing, our location matters

¹⁵ Heida A. Campbell and Stephen Garner, *Networked Theology: Negotiating Faith in Digital Culture* (Grand Rapids: Baker Academic, 2016), 88.

and influences how we communicate effectively. In my work, being with the staff I hope to support matters in communicating the message I hope to convey.

Unique Chaplain Manager Responses to COVID-19

The coronavirus pandemic provided chaplain managers space to engage each role of their ministry independently. For instance, ministry in 2020 heavily emphasized the work of chaplaincy and counseling independently from the integrated model because it was what necessitated the greatest amount of resources and attention. While each role seemed more silo-ed than usual, chaplain managers continued to serve from each professional role. In 2021 and 2022, the specialized work of chaplaincy and counseling continued, but there was an increase of efforts to support the community through education, vaccination and economic stability. The unique ministry of chaplain managers during the pandemic that stretched beyond the ordinary function rested in ministry with clergy and congregations and partnerships in caring for neighbors as extensions of hope.

Ministry with Clergy

A significant part of my work right during the height of the pandemic was helping local clergypersons and congregations better understand COVID-19, its impact in our community, and avenues to seek medical attention. Clergypersons are not considered visitors in our healthcare system, so they are not limited to remote visitation. However, our department sends weekly updates to our community's faith leaders, encouraging them to partner with chaplains in hospital visitation rather than visiting in person. We also urged faith leaders to use technology in similar ways chaplains do to offer spiritual care. In the summer of 2020, Davie Medical Center's Chief Medical Officer spoke to a

prominent United Methodist Church in Davie County that also serves as a FaithHealth congregation about gatherings and ways to effectively, yet safely, continue its food and clothing ministry. This partnership in caring for our neighbor holistically is another testament to the trusting web of relationships of FaithHealth and the medical center's tradition of partnering with churches in community care.

Extensions of Hope

The FaithHealth model flexed significantly as the ministry works predominately with volunteers and local faith communities. Instead of serving as managers and coordinators of the community health worker aspects, chaplain manager visited community members at home to assist with medication management, food insecurity, at-home COVID testing, and setting up virtual physician visits. Chaplain managers also served on task forces to determine appropriate community safety precautions, ensuring that marginalized neighbors did not fall through the cracks of the social system. In essence, chaplain managers offered a reminder that communities are only as healthy as their most vulnerable members, pandemic or not.

Mary Chase-Ziolek claims “health is a process, not a static state – it moves toward wholeness through health promotion, disease prevention, and coping with chronic conditions. Similarly, health ministry is a process rather than a program, although it includes programs.”¹⁶ As theology praxis of the ministry of chaplain managers is relation, fluid, and coconstructed within the living human web, so is the journey of health and wholeness. The work of the chaplain manager during the pandemic was to align programs

¹⁶ Mary Chase-Ziolek, *Health, Healing and Wholeness: Engaging Congregations in Ministries of Health* (Cleveland: The Pilgrim Press, 2005), 24.

and available resources with the unfolding and rapidly-changing process of holistic health. They managed opportunities, provided spiritual care through the priestly function, and prophetically spoke of hope and justice amid changing chaos.

Our hospital received donations from multiple entities throughout this pandemic. Our local Lowes Home Improvement and community college donated boxes of much needed PPE for our staff members. Local restaurants have prepared lunches for our staff free of charge. Youth groups and elementary schools regularly brought boxes of thank you cards from students in our area. Organizations such as the Crosby Scholars and Spark brought coffee and decorated tiles of appreciation for our staff members. Hope during this pandemic looks like those many faces that dress in scrubs or first-responder uniforms each day, but it also looks like the helping hands of our community that has reached out wanting to help. Chaplain managers coordinated these efforts as well as efforts to return thanks to the community. I coordinated efforts to supply clothing and food to a pantry that often serves our patient.

As Gregory Jones writes in *Christian Social Innovation*, Christians have a clear sense of their purpose within community.¹⁷ In various ways, FaithHealth is rekindling Christian social innovation that led North Carolina Baptists to open an academic medical center in Winston-Salem. Churches in our area stitched homemade masks for hospital staff to hand out to community members. Such an act recalls the initial building project of the then North Carolina Baptist Hospital that ran out of funding before it could purchase drapery and linen for the hospital rooms. The United Methodist Church and Moravian

¹⁷ L. Gregory Jones, *Christian Social Innovation: Renewing Wesleyan Witness* (Nashville: Abingdon Press, 2016), 20.

churches of Winston-Salem gathered to stitch materials for the hospital and make beeswax candles for each patient room. Despite a roughly 75-year time difference, the congregations of our region are still supporting the medical center, its staff, and its patients.

The early days of the pandemic also brought concern for staff members taking the virus home to their children or elderly parents with whom they are caregivers when they remove their hospital badges. Through a partnership with FaithHealth, a United Methodist Church in Davie County set up temporary walls and brought in cots for medical center employees who needed to quarantine. Fortunately, we did not have to use this space, but it was comforting to know it was available if needed.

One of the FaithHealth connectors was also instrumental in advocating for and hosting the county health department at a site in Cooleemee to test for COVID-19 and provide weekly vaccinations. Cooleemee is the most impoverished area of Davie County and it does not have health care options readily available, especially for those without a means of transportation. This partnership between FaithHealth, the health department, and a local congregation embodies the holistic, community health afforded through the FaithHealth program.

Lessons from the Pandemic

As the oldest CPE and chaplaincy program in the south, spiritual care has been part of Atrium Health Wake Forest Baptist since 1940. Since that time, chaplains have been well integrated into spiritual care with patients, their families, and staff members. Chaplains at Wake Forest are leaders in clinical bioethics, the employee assistance fund, and advance care planning in addition to their traditional spiritual care work. Since

COVID-19, chaplains and CPE students have not been involved as personally in the interdisciplinary team consultations and are not physically seen as often since daily rounds on clinical units were suspended.

Likewise, CareNet counselors have offered telehealth since March. While this is excellent vehicle for support, it does limit our client populations to those with internet access and inhibits those who walk into one of our centers for support. FaithHealth community engagement also paused any new referrals during COVID-19 since so much of the work of our volunteers and staff members are located in the homes of patients.

In addition to chaplaincy and counseling being a step removed from direct care and collaboration and FaithHealth limiting its exposure, COVID-19 had impacted our influence on a holistic method of healthcare delivery. Once engrained in the decision-making process, COVID-19 has changed how involved chaplains can be in promoting spiritual care and support. While COVID-19 is a reality present with us for the foreseeable future, we as leaders need to give careful thought as to how we will begin reintegrating in ways that promote holistic healthcare while adequately considering the health and safety of everyone involved.

In *Creating Great Choices: A Leader's Guide to Integrative Thinking*, Jennifer Riel and Roger Martin explore opposable thinking as a tool to “create tension between ideas...to develop new answers to challenging problems.”¹⁸ Riel and Martin suggest that this practice of integrative thinking is best used when either-or decisions are too painful

¹⁸ Jennifer Riel and Roger L. Martin, *Creating Great Choices: A Leader's Guide to Integrative Thinking* (Boston: Harvard Business Review Press, 2017), loc. 44 of 3374, Kindle. The idea of opposable thinking has root in the opposable thumb, which is used to hold tension.

to make and thus one decision is insufficient.¹⁹ While ministerial leadership often requires difficult decisions that affect people's lives, COVID-19 brought a host of problems that required leaders to engage in integrative thinking. As a leader within a hospital system, I witnessed COVID-19 challenging the assumption of safety, well-being, and the speed of science and technology within the current healthcare context. We chose to approach this pandemic opposably by seeking new paths when opposing options seemed inadequate. Perhaps we are learning how to improve health care in general and spiritual care in particular through our engagement of integrative thinking to this point of the pandemic.

By considering opposition as a means of growth rather than a set of problems, we can seek out new ways of integrating into the health system and promoting holistic health in novel ways. COVID-19 has forced us to create something new that did not exist prior to February 2020. As an example, chaplains within our system have never used videoconferencing as a way of providing spiritual care, but it opens possibilities for including out of town family members in family consultations and provides ways for patients to meet with their entire medical team at once. Part of our spiritual care team's work is to explore the various possibilities afforded to us during this pandemic.

COVID-19 forced chaplaincy in our medical center to face numerous win-lose situations. We know that providing in-person spiritual care is the best modality, but doing so risked the health of the patient and our own health. Using technology to provide spiritual care reduces exposure risk, but can increase the sense of otherness and loneliness experienced by our patients. These win-lose situations also extended to staff care. Staff

¹⁹ Riel and Martin, *Creating Great Choices*, loc. 87 of 3374.

members were educated on safe ways to care for COVID-19 positive patients, but then told there is a global shortage of the very supplies to keep them safe. The need for spiritual and emotional care among staff members was evident, but there were many questions about offering such safely. It appears our ministry would either maintain safety or provide genuine spiritual care. Fortunately, our leadership team engaged in integrative thinking to escape these binary options.

Since February, we moved chapel and weekly meditation to a WebEx conference call and I send out a weekly video of encouragement for our staff members. Most of the nurses' stations in our hospital are enclosed in glass, so rather than dropping in to check on staff member, I knock three times and wave at our staff members. This is just a simple practice to help our staff know they are not alone and a reminder to pause throughout the day for a centering moment. I also kicked off a "Forty Days of Davie" campaign to strengthen our staff by hearing some of the voices of our hospital's leadership during the expected peak in our area. I asked each leader to write an encouraging message or share a quote of no more than 250 words that could be emailed to all staff members during the forty-day period. Furthermore, we initiated a "Caring for Your Soul" Microsoft Teams page to post these messages and other prayers throughout the week. Although we connected in differently than we did during pre-COVID-19 times, we found unique and thoughtful ways to strengthen and encourage our staff members.

We are committed to our work of caring for the vulnerable spiritual, emotionally, and physically, so we have adapted to challenges to ensure we do not lose sight of our call and commission within the community. Perhaps most importantly, we have learned to value resilience and the need to care for ourselves as best preparation for caring for

others. Spiritual care is difficult by itself, but when paired with journeying with individuals to best navigate their support, it can take a toll on one's health. We regularly encourage our staff to take care of themselves and develop their resilience through self-care.

We developed during crisis because we were forced to do so. Yet, in other ways, being forced to think outside the box spurred our imagination to offer the core of spiritual care through a new modality. Instead of choosing from the options available, we engaged in integrative thinking to form a new path for ministry during COVID-19. We engaged in metacognition, empathy and creativity to explore ministry possibilities rather than settle with the known option.²⁰ We were also able to engage opposably because of the trust built with our staff members. Our staff trusted us to provide spiritual leadership in a way that was both authentic and safe.

²⁰ Riel and Martin, *Creating Great Choices*, loc. 690 of 3374.

Chapter Four

Evaluation, Opportunities, and Innovation

The chaplain manager role is a model that incorporates clinical spiritual care and public health into one role with the network hospitals of Atrium Health Wake Forest Baptist. This position arose out of the identity and mission of FaithHealth of removing barriers between a hospital-based model of healthcare and one that is community-centric. This chapter explores the experience of the three chaplain managers who currently serve at Davie, Lexington, and Wilkes Medical Centers and the perspectives of leaders within the Atrium Health Wake Forest Baptist system. Additionally, this chapter explores areas of opportunities and future innovation as FaithHealth addresses needs within medical centers and broader communities.

Chaplain Manager and Leadership Voices

Dianne Horton, Lexington Medical Center

Rev. Dianne Horton has worked at Atrium Health Wake Forest Baptist since 2010 and served Lexington Medical Center as the chaplain manager since 2015.¹ Dianne was ordained in the National Baptist Convention USA Inc. and is a Board Certified Chaplain (BCC).² When asked about strengths of the FaithHealth chaplain manager role, Dianne identifies the encouragement and flexibility to work both inside the walls of the medical center and beyond its wall and the continuity of care the position affords her ministry.³

¹ Dianne Horton gave permission to use her name.

² While Dianne is a board certified chaplain, the role only requires chaplain managers to be eligible for board certification.

³ Dianne Horton, interview, February 23, 2022.

Additionally, Dianne appreciates being able to engage with hospital staff both in the hospital and in various functions of the community. The second question revolved around the greatest impact of her role as the chaplain manager at Lexington Medical Center. According to Dianne, the most impactful area of her work is its connection to meeting the needs of individuals where they are. FaithHealth community engagement, according to Dianne, is an extension of that presence beyond the hospital room, but it is still a ministry of meeting needs rather than offering a fix.⁴ While the work of FaithHealth community engagement certainly ministers through tangible items such as food and clothing, the function is to increase agency, foster resiliency and advocate for social change. It is proactively working upstream rather than merely reacting to situations. For instance, it is mobilizing a transportation ministry to help patients travel to their medical appointments rather than canceling appointments or paying for cab rides from other counties.

When asked about the greatest challenges for her work, Dianne says that she is challenged by time constraints, education, awareness of role and the need for additional employees.⁵ Time, according to Dianne, is of essence when carrying as many roles as chaplain managers carry, especially when the work of spiritual care and community engagement is time consuming and emotionally taxing. Connected to the constraint of time is the lack of hospital employees to carry out the ministry of the FH division. While chaplain associates and connectors are helpful, their limited abilities to chart in patients' electronic medical record and carry out the full ministry of chaplaincy and community

⁴ Horton, interview.

⁵ Ibid.

engagement limit the ways in which they engage in ministry. Additionally, connectors work in the communities of each medical center, but they work independently from each hospital. Chaplain managers are often triangulated by the disconnection between connectors and the medical center, so having additional staff members who are employees of the medical center would ease the time restraint on chaplain managers who find themselves between entities further assist chaplain managers in the continuity of care.⁶

The other two challenges Dianne identified are educational needs and the awareness of chaplain managers' roles within the community. Dianne notes that divinity school does not train individuals to understand public health theory, social work practices, or an in-depth knowledge of bioethics. While chaplains generally operated in some conversation with these disciplines, Dianne suggests that it would be helpful to have additional training since these areas encompass such a large portion of the chaplain manager role. Additionally, Dianne suggests rethinking the title of chaplain managers since traditional chaplains would generally not attend some of the community meetings or serve as contributors to the CHNA like chaplain managers do.

Graylin Carlton, Wilkes Medical Center

Rev. Graylin Carlton has served as a chaplain with Atrium Health Wake Forest Baptist since 2014 and has served as the chaplain manager of Wilkes Medical Center for the past five year.⁷ Graylin, who self-identifies as African American, is an ordained

⁶ Horton, interview.

⁷ Graylin Carlton gave permission to use his name.

minister connected to a Missionary Baptist Church and grew up in Wilkes County, which Graylin reports as having positive and negative impacts on his ministry within the hospital and greater community.⁸

The strengths of the FaithHealth chaplain manager role that Graylin highlights include the removal of barriers between the medical center and the community, presence of chaplains in the daily life of the hospital and community and the increase of diverse voices intentionally included in the FaithHealth model.⁹ Graylin appreciates the flexibility to care for patients regardless of their admissions status and the freedom to follow patients as they transition from a hospital stay to the places they call home. This freedom increases the presence of the ministry of FaithHealth by holistically supporting individuals where they are. Furthermore, Graylin believes the FaithHealth chaplain model increases the opportunity for diversity in patient care by welcoming other members of the community into FaithHealth's continuity of care.

For instance, Graylin notes the centrality of the barbershop in the black community of Wilkes County versus the central role of the black church in other communities he has served. According to Graylin, the barbershop was his strongest medium of support in messaging health information in the height of the pandemic. Without pre-established relationships before the pandemic, the barbershop probably would have played a different role in the pandemic than it did in this community.¹⁰

⁸ Graylin Carlton, interview, February 23, 2022.

⁹ Ibid.

¹⁰ Ibid.

The challenges of the FaithHealth chaplain manager role include financial constraints, the need for additional hands, and self-care. Although Wilkes Medical Center has a foundation to financial subsidize the work of FaithHealth, the need is greater than the available support. Second, with such a demand for services, Graylin identifies the lack of additional hands, such as volunteers willing to serve, administrative support, and trained chaplains, as a challenge to the FaithHealth ministry. In addition to practitioners, Graylin would like additional administrative support in assisting employees through the emergency financial assistance fund and establishing new service vendor agreements to help patients with services such as transportation in each community. Finally, Graylin identifies self-care as a significant challenge, especially through the pandemic. As the outermost campus from Atrium Health Wake Forest Baptist, Graylin expressed a notion of being isolated from other members of the FaithHealth team. Furthermore, Graylin has had difficulty in recent years hiring chaplain associates with a master's degree and a unit of CPE in the area he serves.¹¹

Adam Ridenhour, Davie Medical Center

I have worked at Atrium Health Wake Forest Baptist since 2014 and have served as the FaithHealth chaplain manager at Davie Medical Center since January of 2017. I am a board certified chaplain, a provisionally licensed clinical mental health counselor (LCMHCA) in North Carolina, and an ordained minister affiliated with the Cooperative Baptist Fellowship. I am the first chaplain at Davie Medical Center since its inception eight years ago. Being the initial chaplain at a medical center had its benefits: I was a part

¹¹ Carlton, interview.

of the story in the beginning rather than being the added character within a set plotline; I helped develop criteria for hiring chaplain associates; and I framed spiritual care and chapel developments within the context of the FH division but with attention to the nuance of the Davie County community.¹²

There were challenges in this freedom, however. For instance, I spent significant time in the first year of the medical center existence educating staff, providers, and community members about the role of chaplaincy within a community-based hospital. I struggled to secure philanthropic support for our chapel when sharing the interfaith platform of a medical center chapel to predominately conservative constituents. I also struggled to maintain a healthy work-life balance when promoting spiritual care services as 24-hours-a-day when I was the sole provider throughout the first year.

The strength of the FaithHealth chaplain manager role, I think, is the ability to holistically serve patients and community members. I also appreciate that it is a specialized ministry that takes the form of a generalized one; the work of spiritual care is specialized, but the usefulness of the ministry's tools can be applied to a broad spectrum of needs. For instance, the skills of listening for what is being said and what is not being said works as well in soup kitchens, consult rooms, elementary school libraries, or church fellowship halls as it does in hospital rooms. Second, a strength of the FaithHealth chaplain manager model is the platform it offers chaplains to advocate for those marginalized at multiple levels of the medical center. This platform includes meeting the

¹² As previously mentioned, the chapel pews offer an example of this contextual consideration. The chapel at Davie Medical Center is interfaith and its services and prayer book resemble what is offered at the Winston-Salem campus. However, the chapel pews are traditional and they are refurbished furniture from the former Davie County Hospital.

tangible need of patients that arise in the hospital as well as the future commitment and investment of a medical center to a local community through the CHNA and implementation plan. Third, as the chaplain manager for the smallest medical center in the Atrium Health Wake Forest Baptist region, I am thankful for this integrated role that provided a full-time ministry opportunity for me rather than three part-time positions.

The challenges of the FaithHealth chaplain manager role are self-care, time, and financial resources. Davie Medical Center is the only satellite campus without a health foundation, so financial resources are nearly funded completely through the medical center budget. As our system adapts to a new landscape under the strategic partnership with Atrium Health, there are discussions of local philanthropic efforts to support the ministry of FaithHealth in Davie County. For now, our ministry relies heavily on the medical center's budget.

Time is the second challenge for my ministry at Davie Medical Center. Serving patients and clients through the work of chaplaincy, counseling and community engagement is a ministry of relationships that take time to foster. Practically, charting in two different electronic medical record systems, attending staff and community meetings in each department, and maintaining continuing education hours for chaplaincy and counseling heavily impact the amount of time available each week. Without accounting for crisis calls, counseling is the most predictable portion of my role. Chaplaincy and community engagement are rarely predictable ministries that follow a strict 8:00 AM – 5:00 PM schedule.

Self-care is perhaps the greatest challenge for me in relationship to my role as FaithHealth chaplain manager. While my context and role is different than that of a

congregational pastor, I share the need to have a community of friends and trusted colleagues to “...experience a sense of belongingness – community, fidelity, and mutuality...” to flourish in my ministry.¹³ I often feel guarded around coworkers and our congregation, partly because of projections and expectations they hold around the office of ordained minister and partly because my setting of boundaries is a necessary part of a healthy ministry. I welcome new experiences of belongingness as a way to maintain or enhance my sense of well-being.

My role as a chaplain manager is like the role of a congregational pastor in constantly being on-call. I have additional support that covers calls most weekends, but I always serve in a backup role to the associate chaplains. Fortunately, the administrators of the hospital I serve value self-care and the necessity of disconnecting from my caregiving role. But, other pastors and chaplains find themselves with less empathetic expectations. Congregations and organizational leaders need educational opportunities to understand how to contribute to their pastor’s well-being and the role they assume in the pastor-congregation relationship. The lack of such education leads to misunderstandings and unmet expectations that negatively impact the pastor’s ability to flourish.

In summary, the chaplain managers at Davie, Lexington, and Wilkes Medical Centers find the strengths of the FaithHealth chaplain manager role includes the flexibility and encouragement to minister broadly, the invitation to meet individuals where they are from a bio-psycho-social-spiritual perspective, and the inclusion of diverse partners and perspectives in the continuity of patient care. Gunderson describes

¹³ Matt Bloom, *Flourishing in Ministry: Emerging Research Insights on the Well-Being of Pastors*. (University of Notre Dame, 2013), 35.

the flexibility and freedom of the FaithHealth to minister out of the needs that arise in a community as an element of intentional design. In an email correspondence, Gunderson writes:

The FH-CM [FaithHealth chaplain manager] role helps make visible the integrated FH theoretical paradigm that lives not just in the bio-psycho-social-spirit model, but also illuminated by the Leading Causes of Life, Strengths of Congregations, Boundary Leadership and Religious Health Assets. The FH-CM job description is designed to allow the person in that role to live into the daily work of helping that complex theory to be expressed in the lives of people in and around smaller medical centers and more human-scale communities. I believe that this living reality makes the theory more visible and about to be grasped and thus adapted in many different settings. It looks different even between relatively similar settings such as Davie, Lexington and Wilkes. People in Buffalo and Uvalde and San Bernandio can look here and realize what they could do in their own places.¹⁴

The chaplain managers also mention items that hinder the effectiveness of their work in their respective communities. These challenges include financial support, the need for additional partners or teammates across the FaithHealth platform, the constraint of time and its connection to self-care, and educational needs to help encompass the expanded role of chaplain manager as contrasted with a traditional chaplaincy role.

Leadership Voices

Chad Brown, President, Davie Medical Center and Wilkes Medical Center

Dr. Chad Brown has an interesting role in our health system as the President of two regional health system.¹⁵ As a leader with a doctorate degree in public health, Chad values the mission and identity of FaithHealth and stands as a strong supporter of

¹⁴ Gary Gunderson, interview, June 7, 2022.

¹⁵ Chad Brown gave permission to use his name.

FaithHealth inside the medical center and beyond. Chad depicts the role of a community hospital as small business within a community that must build relationships of trust to be successful.¹⁶ The trust necessitated by a local presence is more than a marketing brand or a financial investment in a community; it requires, according to Chad, a missional approach to healthcare that humbly embraces healthcare's transition from a volume to value approach.¹⁷

Herein lies the value of FaithHealth from Chad's perspective: FaithHealth is a formulation of trust, especially in rural communities without a plethora of social services but with an abundance of faith communities.¹⁸ According to Chad, faith continues to play a vital role in the communities he serves and faith communities are vital partners in the health of a community. Chad appreciates the generalist role of chaplain managers that function with flexibility and nimbleness in addressing spiritual care, behavioral health and social concerns in the medical centers and broader community.¹⁹

Emily Viverette, Director, Chaplain and Clinical Ministries

Dr. Emily Viverette is the Director of Chaplain and Clinical Ministries and the Director of FaithHealth Education.²⁰ Emily serves as the direct supervisor for the chaplain manager roles at Davie, Lexington, and Wilkes Medical Center. According to

¹⁶ Chad Brown, interview, January 25, 2022.

¹⁷ Ibid.

¹⁸ Ibid.

¹⁹ Ibid.

²⁰ Emily Viverette gave permission to use her name.

Emily, chaplain managers are effective in their respective communities because they are “trusted community liaisons” between hospital-based medicine and other local areas of health and spiritual support.²¹ Chaplain managers, according to Emily, have found ways to “leverage social capital and connect with faith communities” in novel ways within the Atrium Health Wake Forest Baptist system.²² Emily also highlights that chaplain managers form interfaith partnership in their respective community, enriching the diversity of voices in conversations of health and wellness.²³

Bryan Hatcher, President, CareNet Counseling

Dr. Bryan Hatcher is the President of CareNet Counseling and has served with the organization since 1999.²⁴ According to Bryan, the value of the FaithHealth chaplain manager role that combines chaplaincy, counseling, and community engagement beyond each in their respective roles is the expanded toolbox of interventions and the platform to advocate for preventative care and healing.²⁵ By occupying an integrated role, practitioners are aware of additional resources from each field and have a better understanding of how to engage in preventative or proactive care because of this broader perspective.

²¹ Emily Viverette, interview, January 24, 2022.

²² Ibid.

²³ Ibid.

²⁴ Bryan Hatcher, interview, August 29, 2022. Bryan gave permission to use his name.

²⁵ Ibid.

Although Bryan is the president of a counseling network, he is a proponent of the generalist model of FaithHealth and the gift that model offers in learning from other members of the team. According to Bryan, FaithHealth practitioners are generalists and specialists who constantly move between these models to best care for patients, clients and community members.²⁶ But, Bryan notes that FaithHealth team members are generalists because they are trained in multiple areas to care for a variety of needs rather than generalists because there are not enough people to account for the variety of needs within a community. Bryan shares that far too often faith leaders are called on to be resources in areas they have little to no trainings, such as during a mental health crisis. The FaithHealth generalist model is about training and equipping practitioners to address a wide range of spiritual, behavioral or social needs.²⁷

One concrete way CareNet Counseling is embracing the FaithHealth model is through educating the Atrium Health Wake Forest Baptist system on trauma-informed care and embracing current findings in neuroscience research. Bryan believes trauma, treatment and the role of resiliency as a proactive tool is common ground between faith and science and one that can significantly impact our society.²⁸ Although CareNet continues to offer traditional, individualized sessions for clients, the embrace of public health and the generalized model of FaithHealth is challenging how this model can offer assistance to more people in less time. The counseling needs that surfaced throughout

²⁶ Hatcher, interview.

²⁷ Ibid.

²⁸ Ibid.

COVID-19 are key indicators of the need to assistance in a new way that helps support more individuals.

Gary Gunderson, Vice-President, Division of FaithHealth

Dr. Gary Gunderson is the Vice-President of the FH division and the founding leader of the FaithHealth movement.²⁹ When asked about the importance of FaithHealth chaplain managers and the possibility of the chaplain manager role being adapted for other health systems, Gary states:

The FH CM [FaithHealth chaplain manager] role is crucial in two fundamental ways for medical centers serving communities in ways that are sharply different than in larger cities and more highly specialized medical assets (as in Winston). The first challenge for the FH-CM is to ensure that all the moving parts of the modern FH model are present, aligned and integrated with the local social/faith ecology. The needs and opportunities are not less complex, but the staffing is necessarily more nuanced with many more part-time and informal roles. The temptation is to just leave important aspects out. *Job one is keeping that complexity.*

The second role is to focus on equipping, adapting and aligning the FaithHealth assets in the local ecology. In a large medical center we may have the luxury of having staffed roles available and the task is simpler. In a smaller ecology, the FH-CM will often be training non-FaithHealth staff, external people and volunteers to play roles within the FaithHealth model which is marked by a bio-psycho-social-Spirit paradigm. The FH-CM has to see in other people what they may not see in themselves. The smaller social scale makes this both doable and necessary, but only if the FH-CM job description makes that expectation clear.³⁰

Constraints as Opportunities

While the FaithHealth model has many strengths, the FaithHealth chaplain manager named areas of limitation for this model as well. These limitations, or

²⁹ Gary Gunderson gave permission to use his name.

³⁰ Gary Gunderson, interview, June 7, 2022.

constraints, offer opportunities for growth and flexibility. In *A Beautiful Constraint: How to Transform Your Limitation into Advantages, and Why It's Everyone's Business*, Adam Morgan and Mark Barden reframe constraints from something limiting and restrictive to something “fertile, enabling and desirable.”³¹ According to the authors, a contemporary challenge of leadership is the ability to grow within restraints, framing restraints as an impetus for ingenuity.³² The challenge for leaders, then, is to positively leverage restraints rather than eliminating the inevitability of constraints in our work.³³ While not all constraints are beneficial, the intentional choice to find beauty in constraints means to see constraints as “an opportunity, not a punitive restriction, and using it as a stimulus to see a new or better way of achieving our ambition.”³⁴

As I reflect on my own context of ministerial leadership, the greatest areas of constraint for me are those of resources and time. The hallmark of pastoral care as a chaplain is relational ministry through presence. Often times we are present with those who suffer acute or terminal illnesses, being conduits of hope and illumining some sense of the Divine amid suffering and loss. But, our work also includes celebration of life and the process of being made whole, so there is an overt life-cycle component in this ministry context. While the specialization of chaplaincy and counseling often shifts our ministry toward specific needs that are specific to physical, mental, emotional and spiritual health in its primary sense, there is a generalization to this work that include the

³¹ Adam Morgan and Mark Barden, *A Beautiful Constraint: How to Transform Your Limitation into Advantages, and Why It's Everyone's Business* (Hoboken: John Wiley & Sons, 2015), 2, Kindle.

³² *Ibid.*, 3.

³³ *Ibid.*, 6.

³⁴ *Ibid.*, 7.

whole of an individual's experience beyond his/her hospital admission. Chaplain managers are also requested to help families with meals and housing while their loved one is hospitalized. We are called on as liaisons between patients and homeless shelters and treatment centers. And, we are also called when the living conditions of a patient will likely impede a patient's continued healing when discharged from the medical center.

The specialized ministry of chaplaincy is constrained by time, but this is a constraint that is not easily transformed. Patient-to-chaplain ratios average 200:1 nationally, so one mechanism of transformation for this constraint is to offer group support.³⁵ Unfortunately, that is not a possible modality for all patients and COVID-19 has greatly diminished the potential of group support for the foreseeable future. Often, we meet terminal patients in their final moments, so time constraints are inevitable in our work.

The generalized ministry of chaplaincy, however, offers transformational space to leverage constraints as possibilities. The constraint of resources is one of the most difficult constraints in our generalized ministry. While chaplains listen to the struggles of patients within the medical center and the broader community, there are often few tangible resources we can offer those in need beyond our presence. Most of the situations we hear are complex, multi-layered, and systemic issues that are not easily rectified. To engage persons at the level necessary to affect tangible change would easily transition us

³⁵ Staffing models for hospital chaplaincy span a wide spectrum, but the most favorable chaplain to patient ratios are usually in religiously-affiliated medical centers. Additionally, chaplaincy tends to follow hospital staffing models around total hospital census and population density (Flannelly, Handzo and Weaver 2004). Recently, however, studies such as one published by Antoine et al suggests staffing based on role, goal, and function of chaplains within the organization (2020). Since the chaplain manager role falls outside of traditional spiritual care roles, the Antoine et al model, especially given the fluctuation of volume in inpatient, outpatient, staff, community engagement clients and counseling clients.

past a boundary of our training, our scope of care, and our commitment of being a spiritual and emotional presence for a defined portion of an individual's journey.

As previously mentioned, the ratio between chaplains and patients are not favorable to spending significant time with one individual. While the need may necessitate time, such a choice would take away from time spent with other patients. Furthermore, the process of walking with someone through the process of obtaining housing or beginning a recovery journey from substance abuse is a lengthy process that may be best suited for a case manager's expertise.³⁶

Innovation

Healthcare is evolving. Whereas healthcare in the twentieth century focused on discovering the latest technologies to react to a plethora of medical conditions, twenty-first century healthcare seems to have a renewed interest in the proactive health of the public through preventative care and social determinants of health. In various ways, healthcare chaplains are following a similar arc of evolution. Chaplaincy has traditionally partnered with behavioral health to hold footings in both science and humanities. This traditional model was formed by the notion that chaplains are involved in complex psychiatric and bioethics cases that required expertise in philosophy and social sciences. While chaplaincy today continues to thrive in the complexity of the healthcare system, there is a shift to also include chaplains in the community engagement work of population health and preventative health. Such a focus renews the relational element of

³⁶ Often the patients we assist with housing and treatment in the role of chaplaincy are those who come to the medical center for outpatient procedures or appointments. As a result, they would never encounter a case manager or social worker during their visit. This is often the reason chaplains are consulted for such cases.

chaplains ministering within the walls of the hospital as well as in partnership with other ministries in the community. In addition to partnerships within the behavioral sciences and ethics, chaplains are now conversation partners in the work of public health.

John Lederach in *Moral Imagination* defines moral imagination as “the capacity to imagine something rooted in the challenges of the real world yet capable of giving birth to that which does not yet exist.”³⁷ This challenge is certainly full of real world, systemic struggles with opportunities yet to be seen.

Educational and Organizational Opportunities

Since the formation of the School of Pastoral Care at Atrium Health Wake Forest Baptist in 1947, pastoral care and pastoral counseling have worked together to provide holistic care. Due to the rise of managed care organizations and the need for pastoral counselors to seek licensure, pastoral counseling separated from the CPE model in the 1990s to form its own residency program for provisionally-licensed therapists and clinical social workers. Since then, CPE and the CareNet Counseling residency share a similar pedagogy and engage in joint didactics when feasible to do so, but much of their training and conversational partners come from their respective program.

A significant development in 2019 occurred when the American Association of Pastoral Counselors announced a merger with the Association for Clinical Pastoral Education. Furthermore, many divinity schools and seminaries now offer dual degree programs that include a Master of Divinity with a Master of Arts in counseling or a Master of Social Work degree. While most of these students pursue licensure and enter vocational counseling careers, a portion of these students choose to pursue both training

³⁷ John Paul Lederach, *The Moral Imagination: The Art and Soul of Building Peace* (Oxford: Oxford University Press, 2005), viii.

in chaplaincy and in counseling. I am a graduate of one of these programs and my vocational identity includes both chaplaincy and counseling.

Although the journey is significant, community hospitals need the adaptability of an individual certified in chaplaincy and licensed in counseling. Not every hospital has the number of employees as our division within Atrium Health Wake Forest Baptist, so a dually-trained clinician-chaplain could promote holistic healthcare in community hospitals and meet the community's needs of having a chaplain in the hospital and a counselor in the community. Many community hospitals have only a part-time chaplain or a volunteer chaplaincy program, so this would also create career opportunities in a field oversaturated with trained chaplains for the number of hospital positions available. As public health continues to provide strong partnership with spiritual care providers, this would also provide a way to introduce communities to FaithHealth and relational community engagement.

The chaplain managers from network hospitals and the directors of chaplaincy, community engagement, and CareNet counseling need to be involved in this strategic process. The responsibilities of network hospital managers need to serve as a foundation for this conversation since they are already involved in this hybrid work. Through the expertise of our directors, we need to discuss ways to scale our community hospital model and create opportunities for dual degree seminary students to pursue their interest in integrated pastoral care, counseling, and community engagement. Each member of the strategic process is aware of the requirements of the profession, so we would need to discuss how to provide cross-trainings that meet requirements for chaplaincy and counseling in a reasonable timeframe without minimizing the training process.

Returning to Morgan and Barden’s restraint groups, the constraint of time and foundation need to be considered in this vocational venture. This is a developmental process that will take time to survey community hospitals’ interest in a hybrid spiritual care program and work through the specifics of each accrediting body. While there is a shared foundation between chaplaincy and counseling, many of the practitioners that remember that foundation are retired. While history and our current model provide some content to the context of a hybrid model, we would need to do extensive research on the viability of the model outside of the Atrium Health Wake Forest Baptist system and the scalability of this model beyond the personalities and skillsets of our system’s team.³⁸

Gregory Jones’ *Christian Social Innovation* immediately comes to mind as we consider setting forth a new path within the discipline of pastoral care and counseling. According to Jones, Christian social innovation “involves bringing the rich resources of the Christian faith to bear on the mindsets, practices and traits of social innovation.”³⁹ The Baptist State Convention used social innovation as they dreamed what was then North Carolina Baptist Hospital into existence. The spirit of Christian social innovation led that same group to hire a chaplain in the 1940s and create the premier CPE program in the South under Anton Boisen’s students, Richard Young and Wayne Oates. That same spirit could be tapped into again as we dream about the possibilities of this integrated role and its impact on small, rural communities.

³⁸ In addition to the timing required to fulfill training and the threshold for each professional body, namely the National Counselor Exam for counseling and board certification for chaplain, pursuing credentials and necessary continuing education is expensive. Perhaps another opportunity is finding ways for supervision and continuing education to suffice the requirements of both programs without sacrificing quality.

³⁹ L. Gregory Jones, *Christian Social Innovation: Renewing Wesleyan Witness* (Nashville: Abingdon Press, 2016), location 122 of 1644, Kindle.

Latinx Practitioners

In recent years, our leadership team has noticed a troubling trend in the lack of Latinx chaplains and counselors within the piedmont of Winston-Salem. There are few bilingual chaplains and counselors in the area as well. While pastoral care and counseling can be offered through the assistance of a translator, the rapport between client/patient and caregiver suffers considerably. Our team is curious as to why this demographic of chaplains and pastoral counselors is significantly underrepresented in the piedmont area of North Carolina and how we might change the statistical landscape.

Two primary voices to include in conversation are Francis Rivers Mesa, a CPE supervisor and FaithHealth connector to the Hispanic League, and Camila Pulgar, CareNet counselor and PhD student in counseling education. Francis was the first to highlight the disparity in our region and has the training credential of a CPE certified educator. Camila is the only bilingual counselor within CareNet counseling and is focusing her dissertation research on Latinx pathways to counseling careers. Once again, the network chaplain managers need to be in this conversation since there is such a need for behavioral health resources and practitioners within these communities. Another voice to include in conversation is area Latinx pastors who may be able to offer some insight into the disparity of Latinx and bilingual chaplains and pastoral counselors in our area.

The greatest constraint is foundation for this initiative. I can listen to what might deter Latinx individuals from pursuing careers in chaplaincy and counseling without assuming I know the crux of the problem. Many of us wonder how the stigmatization of mental health influences this statistic. Generally, Latinx individuals make up the smallest

percentage of the demographics among active clients, but we lack data to suggest whether this is because of the mental health stigma or it is due to the lack of Spanish speaking providers in our system.

Trauma Informed Care

The future of hope within the FH division rest heavily on the pioneers of innovation that created a nationally-renowned CPE program to engage the future as opportunity. A common thread between chaplaincy, counseling, and community engagement is the notion of resiliency and trauma-informed care. While each discipline defines resiliency differently and offers different avenues to promote resiliency, each department has some way of talking about resilience. FaithHealth offers a platform to champion resilience without the concept being used as a management principle to increase productivity.⁴⁰

Values-Based Healthcare and Revenue-Generating Roles

A struggle that hospital administrators encounter when developing or growing a spiritual care or community benefit department is that these roles are non-revenue generating roles. Fortunately, counseling is revenue generating and thus offers some way to traditionally justify a FaithHealth spiritual care role for those who are also licensed counselors. While the majority of the FaithHealth role is not revenue producing, it is a division that champions population health, preventative care, values-based healthcare, and general community trust through established webs of relations. Furthermore, as

⁴⁰ When I offer staff care, I am increasingly aware of how tired frontline staff members are of hearing about resilience. Some share of how resiliency has been “cheapened” throughout the COVID-19 pandemic to ensure stability in staffing. Housing resiliency training in spiritual care and counseling allows it to be used for therapeutic purposes instead of focusing on its byproduct of employee satisfaction.

expanded upon in chapter three, the FaithHealth chaplain manager role covers a plethora of roles within and beyond the medical center. It is cheaper to pay for one salaried position than it is for the on-boarding and salary of multiple roles.

An area of opportunity for values-based healthcare is determining how to measure values and the assets the values-based model offers a medical center. At Atrium Health Wake Forest Baptist, the work of FaithHealth chaplain managers in the community is counted toward the community benefit reimbursement for the medical center, but there must be a better way to qualify the worth of values-based healthcare beyond this mere quantifiable metric. Additionally, how is the role of a generalist valued in today's healthcare environment? Perhaps these are areas of further investigation as healthcare embraces values-based care.

Areas of Future Study

There are significant conversations surrounding the relationship between pastoral care and counseling as an extension of the church. It is worth noting that the twentieth century marked a time of transition in ecumenical and interfaith dialogue as reflective in the transition from pastoral care to spiritual care and pastoral counseling to spiritually-integrated counseling. A secondary topic of study could be the relationship of Atrium Health Wake Forest Baptist and Wake Forest University with the Southern Baptist Convention and its response to the Convention's conservative resurgence in the 1990s. These are histories worth noting here, but these significant topics for research are beyond the scope and parameters of this project. Finally, social location and diversity across the regional health system are areas that need continued investigation as well.

Conclusion

The FaithHealth chaplain manager role is a model that seeks to provide holistic care for patients, families and staff through the integration of chaplaincy, counseling and community engagement. It is a unique model that welcomes a relational, coconstructed, complex understanding of spiritual care that leans toward hope with curiosity and humility.⁴¹ It is also a model that respects and values the living human web that situates care within, among, and between “a wider cultural, social and religious context.”⁴² The chaplain manager role reclaims a generalist function within a specialist role; while chaplains, counselors, and community health workers are specialist, this integrated role offers a generalist ministry that adapts to the needs of individual and communal care receivers. Through strategic partnerships and webs of trust, FaithHealth chaplain managers are able to care for those who fall outside the parameters of other social support system. Chaplain managers expand their role to follow patients from the medical center to the community, ensuring continuity of care and access to health care resources.

Additionally, FaithHealth chaplain managers provide a model of staffing that offers full-time employment and embraces the specialized and generalized ministry of clergypersons. In return, medical centers employ a chaplain manager that can offer specialized ministries and serve as a liaison between the medical center and broader community. Finally, such an integrated role provides opportunities to reimagine the relationship between mental health, spiritual care, and community care by providing

⁴¹ Pamela Cooper-White, *Shared Wisdom: Use of the Self in Pastoral Care and Counseling* (Minneapolis: Fortress Press, 2004), 186.

⁴² Bonnie J. Miller-McLemore, “The Living Human Web: A Twenty-Five Year Retrospective,” *Pastoral Psychology* 67, no. 3 (2018), 311.

avenues of theoretical and practical innovation. This is a successful model that effectively ministers to patients, visitors and staff members at Atrium Health Wake Forest Baptist and the communities surrounding its network campuses.

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Biography

Rev. Adam Ridenhour is an ordained minister and endorsed chaplain affiliated with the Cooperative Baptist Fellowship. Adam is a graduate of Catawba College (B.A.), Wake Forest University School of Divinity (M.Div.), and Wake Forest University Graduate School (M.A.). He is a Licensed Clinical Mental Health Counselor Associate (LCMHCA), a National Certified Counselor (NCC) and a Board Certified Chaplain (BCC) through the Association of Professional Chaplains. He is currently pursuing a D.Min. through Duke Divinity School. Adam serves as Manager of Chaplaincy and Clinical Ministries at Atrium Health Wake Forest Baptist Davie Medical Center, which includes the FaithHealth roles of community engagement and CareNet Counseling. Adam plans to graduate with a Doctor of Ministry degree from Duke Divinity School in December 2022.