

2006 CHA Mission Leaders Survey I

A New Study Compares the Role's Strengths, Weaknesses with Those Seen in 1993

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In this first of two articles on a recent survey of mission leaders in Catholic health care, Sr. Patricia describes the survey's results concerning organizational information and the mission leader's role in senior management. In the second article, which will be published in our September-October issue, Sr. Patricia will share results relating to education, qualifications, experience, and compensation.

Mary Kathryn Grant, PhD, writing in this journal in 1999, traced the evolution of the role of mission leader from "mentor to mascot to mainstream." She argued that because the mission leader position is so central to the purpose of Catholic health care, it should be recognized as a profession and integrated in the ministry's organizations.¹

As Grant described it, the role's development has been analogous to that of the early Christian couple Prisca and Aquila (Acts 18, Rom 16:3, 1 Cor 16:19).² This husband and wife were Jewish Christians who, having moved from Rome to Corinth, welcomed Paul into their hearts, home, and local church. They formed a deep spiritual friendship with the Apostle to the Gentiles as he lived with them in Corinth for 18 months. When Paul set sail for Ephesus, Prisca and Aquila packed up their belongings and their lives and accompanied him to carry the Good News, again setting up a church in their home. We recognize that they were not simply Paul's disciples because, in Romans 16, he calls them "fellow workers," noting that they "risked their lives" for him. Their commitment to the Gospel of Jesus was so strong that, when they met a newer Jewish convert named Apollos whose zeal apparently

blurred the Gospel message, "they took him aside and explained to him the way of God more accurately" (Acts 18:26). They who had received the Word embraced it, sacrificed for it, and labored mightily to ensure that its message continued to be advanced and not mitigated.

Contemporary mission leaders in Catholic health care are, like Prisca and Aquila, disciples of the Lord Jesus, leaders within the church, and workers in the vineyard. Today's mission leaders sacrifice their time and talent, working with, mentoring, and counseling others in order to further the reign of God, particularly among the sick and vulnerable.

A common goal across the Catholic health care ministry is the integration into daily operations—the nuts and bolts—of both the unique mission of each organization and the shared mission of Catholic health ministries, in order to further Christ's healing. We are partners in this healing ministry not because of St. Francis or St. Joseph or any of those other wonderful saints, founders, and foundresses, but because we want to continue the healing ministry of Jesus and because we believe that mission must be integrated throughout every aspect of health care organizations. As CHA, our own commitment is to support and enhance the professional role of the mission leader as vital to all levels of Catholic health care, at the same time acknowledging that this does not mean an individual mission leader has to do everything at every single level.

The role of the mission leader in a Catholic health care organization continues to change, as do the competencies and composition of those carrying out this calling. In January 2006, at the request of its Mission Leaders Committee, CHA conducted a survey of all mission leaders in our database—including individuals from systems,

regions, and facilities representing long-term care, acute care, and other health operations.

The committee hoped to garner information for multiple reasons, including strategic planning and ongoing development of the mission leader function. Clearly, the information is also important for recruiting and hiring mission leaders, evaluating the role of mission leaders, and benchmarking certain aspects of the role. CEOs, sponsors, board members, and mission leaders often contact CHA for help in ascertaining what they should be looking for in a mission leader and whether there is a ministry norm. Questions commonly asked are: "How much should we pay?" "Who should report to the mission leader?" and "Can we give them operational responsibility?" CHA hoped to be able to better answer these inquiries by gathering this data.

CHA last surveyed mission leaders in 1993, when the role was still relatively new. It had originated in the 1980s, but was still nascent; and people's preparation for the role varied greatly. Some who had the position were seasoned members of mission leadership within the ministry; others had come to the position from nursing, teaching, religious formation, or administration. Systems and sponsors recognized in these people certain characteristics that would enable them to transfer their skills to the newly developing mission leader role. The networking among mission leaders, both within systems and throughout the ministry, was fairly informal at that time. Competencies for and even the expectations of the position were not very well established. Today we believe that the role is much more acknowledged and respected throughout the ministry. Preparation for it, although still varied, is much more formalized. Networking, both within and across systems and facilities, is much more regular and formal, constituting part of the ongoing formation of the mission leader.

REVIEWS AND INTERPRETATIONS

The preliminary survey results were reviewed by three focus groups—the Mission Leaders Committee; one system's regional mission leaders; and, in April, the more than 120 participants in CHA's Mission Leaders Seminar. The mission leaders who participated in these forums provided valuable insight concerning the significance of some of the data, as well as of the data's implications for their role and organizations and its broader implications for Catholic health ministry. In offering the survey's results in this article, I will include possible rationale for its findings. In

doing so, I will use the feedback offered by these three groups.

A NONSCIENTIFIC SURVEY

Before describing the results, I must make a general disclaimer. We sent an electronic survey to the approximately 700 mission leaders for whom we have e-mail addresses and received more than 350 responses. We could not, however, tabulate the responses in a manner that allowed them to be broken down in regards to system, regional, or facility level. Information provided by those who accessed the survey was placed into a single coffe. In some cases (areas of competency, for example), mission leaders could check off more than one response; if, therefore, one adds up the results in terms of percentages, one finds some discrepancies. Then, too, we did not require that all questions be answered. We realized that not everyone had the approximately 30 minutes needed to complete the survey. In order to get the broadest possible picture, we asked respondents to answer as many questions as they could in the time they had to allot to the project.

The reader should note that, whenever possible, we tried to ask the exact question and offer the identical answer choices as those in the 1993 survey. We wanted to see how the mission leader role had evolved since the 1993 survey. To gauge results in terms of differentiation, we needed to stay in line with what was asked in the earlier survey. This does not mean there were no changes made. In asking about compensation, for example, we included a salary bracket higher than any included in the 1993 survey. We might add that focus groups have already suggested improve-

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ments for the next survey. CHA has taken note of those suggestions for its long-range planning.

QUESTIONS AND RESPONSES

How long, in years, have you served in your present position within this organization?

In 1993, more than 33 percent of respondents had been in the mission role for less than four years; only a very small percentage had been in it for a longer period of time. At that time, the mission leader role had not been in existence for very long.

The 2006 results show that only 12.2 percent of persons have been in the role longer than 10 years. Even today, when the role is well established, most people have been in the position less than seven years. Clearly, this position is unlike that of a financial officer, director of nurses, or nurse manager, for example, in which people may serve for 30 or 40 years. The position seems to be still relatively new and to have a fair amount of fluidity and an evolving job description.

How long, in years, have you served in a similar position at other organizations?

In 1993, 78 percent of respondents had never before been in a position like it. Today, these numbers are a little bit different: 53 percent have never held a similar position; 17 percent have been in a similar position in a different organization.

Why would we ask this? We recognize that today there is movement within the position and an evolving career path. An example of this trend is Dougal Hewitt of Bon Secours Richmond Health System, Richmond, VA. In 1993, he was a director of mission within a large system, assisting the senior vice president with mission projects and programs. Eventually, he moved to Bon Secours Richmond, to serve as director of mission for that local area. Since then, he has been promoted to vice president of the regional system. So there is some movement from one system to another and from one position to another, a trend that the focus groups believe is healthy for the ministry as a whole.

Just as the recruiting and mentoring of top executive positions is part of governance's strategic planning, so, too, should be the recruiting and mentoring of the system's mission leader, another key role. In those systems where there has been a significant turnover of mission leaders, it might be helpful to analyze the reasons for this turnover. Interviews of the mission leaders (both pre- and post-exit) may reveal opportunities for improvement, support, or change that can ensure retention, continuity, and efficacy of the role.

Even though the mission leader role is now well established, relatively few internship or mentoring programs exist to develop the competencies of those who come into Catholic health care from other ministries and positions. Furthermore, it seems that although executive search firms routinely turn to Catholic health care when seeking experienced vice presidents of mission at large systems, others are still in the dark as to where to find persons with the education, competencies, and experience to assume such roles.

What's the title of the person to whom you report?

This is an important question. In 1993, 57 percent of those who completed the survey reported to the president or CEO; 29 percent reported to the CEO. At that time, it was not uncommon in Catholic health care for the president and CEO positions to be separate, so this response is not surprising. Generally, the mission leader reported to one of these persons. Today, 72 percent report to the president or CEO. Some (9.7 percent) report to the senior vice president for mission services.

Who are these mission leaders? They're directors, either at the institutional or system level. Twelve or 15 years ago, systems didn't have mission directors. The early mission leader was like a one-person band, coordinating numerous projects and programs as the role evolved. Today more mission leaders are directors, assuming responsibility for specific areas within a system—for example, pastoral care, spirituality, and leadership development. There is, however, a growing but troubling small number—2.2 percent—of mission leaders who report to the COO or another administrator. Later in this article, we will analyze and discuss what might be the significance of this trend.

Are you a regular member of the executive management team and/or the administrative council?

Whereas 96 percent of respondents answered this question "yes" in 1993, the number has now decreased to 83 percent. This drop may reflect the fact that many directors of mission in large systems or institutions now have accountability through the vice president of mission. As long as the mission vice president is part of top management, we see no problem with the trend. If, however, the vice president is *not* a regular member of the executive management team or administrative council, the result is quite worrying, because it would represent a significant devolution of what Grant called the "mainstream" role of the professional mission leader.

Do you participate in major decision making such as that involved in budgeting, planning, staff education, and other vital activities?

In 1993, 90 percent of respondents said yes. This year, only 78 percent responded affirmatively. Again, this may be a result of the emerging role of directors of mission. But a 12 percent difference is significant and could indicate an undesirable trend.

Please provide an estimate, on a scale of 1 to 4, of your ability to influence the CEO.

This question is one in which the response possibilities were altered from 1993 to 2006. In 1993, the scale was 1-5. In 2006, it was 1-4. In addition, we reversed the scale values. In 1993, 1 signified "extremely influential," whereas 5 signified "absolutely no influence." In 2006, 1 indicated no influence at all and 4 indicated a great deal of influence. We made the change to force respondents to choose something other than what had been the middle number, 3.

In 1993, some 60 percent of respondents believed they had influence. Today, 31 percent still believe they have great influence in executive decision making; another 41 percent believe they have significant influence. When we put those two responses together, they seem to show that the mission leaders believe they possess a strong ability to influence their organizations' leaders.

However, some respondents are concerned—the 2006 numbers are fairly consistent with those

of 1993—that they have little ability to influence. One mission leader used an intriguing metaphor in regard to this question. She said that she often felt like a "trophy bride" brought out for ceremonial occasions and required to smile and say the "right" thing, but with little ability to influence the hard business of the organization. While the reasons for this unfortunate situation may be numerous, they surely demand attention and evaluation if the role is to be effective and the organization's mission is to be integrated throughout.

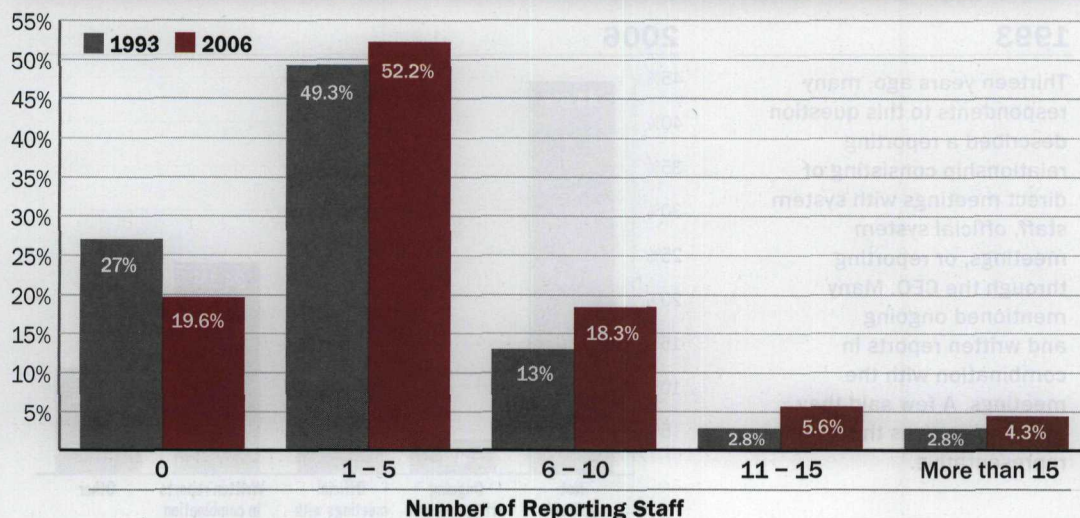
How many professional staff report to you?

This question reflects the scope of responsibility that the mission leader holds within the organization. In the role's early development, many systems intended to keep this person free from operational responsibility so that he or she could attend to the integration of mission throughout the organization. Those systems feared that the supervision of a large number of "reports" might draw the mission leader's time and attention away from his or her primary business.

In 1993, respondents answered the question by simply writing in the number of reports. The largest group of respondents (27 percent) had no direct reports. Very few had more than four reports.

The 2006 survey shows a much larger number of respondents who have from one to five people reporting to them (see **Graph**). The focus group

How Many Professionals Report to You?



discussions indicated that the areas reporting to mission included pastoral care, patient satisfaction, volunteers, patient advocacy, wellness, diversity, organizational foundation, parish nursing, community benefit, and even some more distantly related areas like government relations, public relations, and human resources. In some (although not all) of these situations, the mission leader serves in either a rural institution or a smaller one. Many of these facilities have limits on the financial and human resources they need to operate their various services effectively.

Do you have support staff to assist you in the mission role?

Currently 73 percent responded that they do have such support, so there is a slight increase over that reported in the previous survey.

However, more than a fourth (26 percent) of mission leaders still do not have support staff. Although this may be understandable in a very small institution, it nevertheless leaves the mission leader with a great deal of paperwork and other organizational and clerical responsibilities to complete without clerical assistance, a circumstance that takes him or her away from the position's integrative function.

Of those persons who *do* have support staff, most share the assistant with another administrator or have the assistance limited to a certain number of hours a week. The challenge remains: If the organization really values the position of mission leader, it

should provide him or her with the support and resources needed to do the work at hand.

If your position as organizational mission leader is within a multi-organizational system, how do you formally report to the person at the system level?

In 1993, respondents simply filled in the blank space left at the end of this question. Most indicated that their reporting relationship consisted of direct meetings with the system vice president or through the CEO. In 2006, the largest number of respondents, 44 percent, said the question was not applicable to them. Regarding communication and accountability, most persons said they either had regular meetings with or submitted reports to the system mission vice president (see Graph).

Describe your reporting relationship to the sponsoring group.

In 1993, a significant number of respondents said there was a direct linkage. Many mentioned that they were themselves members of the sponsoring group, as though this alone guaranteed excellent communication with congregational leadership. Several respondents reported to a member of the sponsors' provincial council.

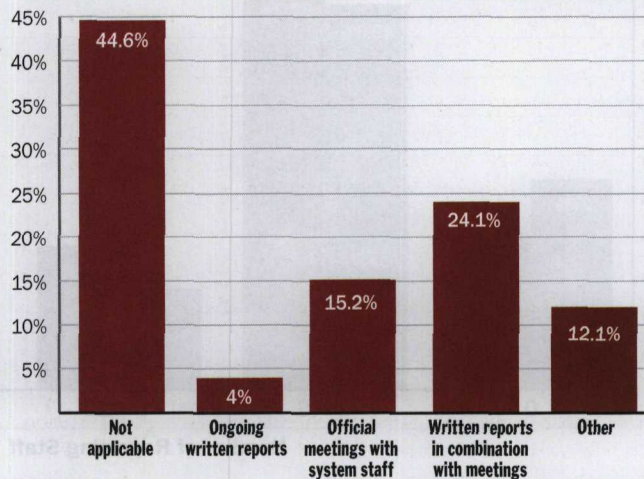
This situation has changed greatly. In the 2006 survey, 14.2 percent of respondents said they had no mechanism for reporting directly to the sponsoring congregation. A smaller number, 8.8 percent, has a "dotted line" (indirect) relationship

How Do You Report to Your System?

1993

Thirteen years ago, many respondents to this question described a reporting relationship consisting of direct meetings with system staff, official system meetings, or reporting through the CEO. Many mentioned ongoing and written reports in combination with the meetings. A few said they were themselves the system representative.

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with the congregation. The largest number checked the survey column labeled "Report indirectly to the CEO or regional VP of mission."

In contemporary Catholic health care, there is general agreement that the CEO, assigned by the board of trustees, is the chief mission executive and has the fiduciary responsibility for the furtherance of the organization's mission. In 10.3 percent of the responding cases, there is a "sponsor liaison." One can conclude that relationships between institutions and their sponsoring congregations vary, a fact reflecting the several models of sponsorship currently operative throughout Catholic health care. Clearly, there is no one best way. Mission leaders, board members, and sponsors must seek and put in place a method of communication and accountability that works for their system and organizational culture.

Which of the following pertain to you?

Responses to this question were computed not in percentages but in the number of responses. The choices and responses for each were:

■ *Are you a member of the sponsoring religious congregation?* Interestingly, 56 were members in 1993, whereas 87 are members today.

■ *Are you a member of a congregation other than the sponsor?* In 1993, there were only three religious serving in a congregation not their own; today there are 25.

■ *Are you a priest?* There was one in 1993; there are seven today.

■ *Are you a sister?* There were 60 in 1993; today there are 103.

■ *Are you a brother?* Although there were no brothers serving in this capacity in 1993, there are two today.

■ *Are you a layperson?* There are 99 today (almost equal to the number of women religious), whereas there were only eight in 1993.

■ *Are you "other" than one of the above?* Thirteen respondents described themselves as "other" in the 2006 survey. The three focus group discussions revealed that some of these 13 persons may be Protestant ministers serving as mission leaders in Catholic facilities.

Are you Roman Catholic? Other than Catholic?

This was the question posed in 1993. In 2006, it was asked in a different way: "Which of the following pertain to you?" Ninety-seven percent of respondents said they were Roman Catholic in 1993; 93 percent say that today. So there is a small but growing number of mission leaders who are other than Catholic.

One need only look at a gathering of mission

leaders at the annual CHA assembly, a system meeting, or related get-together to observe that the demographics of this group are changing rapidly. Although the total number of religious women has increased (as systems and facilities have developed the role), a nearly equal number of laypersons now also serve in this capacity. Statistical studies from the Leadership Conference of Women Religious and individual religious congregations suggest that this trend toward greater "lay" involvement will increase exponentially within the next five years.

Another intriguing development is the fact that a field once dominated by women religious now increasingly attracts academically and pastorally prepared men. And in areas where Catholics constitute a minority of the population, well-educated persons from other Christian denominations serve as leaders in Catholic health care.

In what area(s) do you function as a mission leader?

For this question, the answers outnumbered the respondents, indicating that many mission leaders maintain responsibility for more than one type of health care delivery. Most respondents were from acute care, but around 50 worked in system offices, a significant increase over those who did so in 1993. Similarly, in 1993 only 20 respondents served as long-term care mission leaders, whereas 56 serve in this capacity today. There are currently 17 mission leaders in outpatient centers, and a significant number (31) serve in home care, hospice, adult day care, and rehab centers. Some persons identified themselves as "other." At least three Catholic managed care companies have full-time leaders working to integrate mission throughout these organizations. Moreover, some systems that have large behavioral health components dedicate a mission leader to work with both patients and staff.

What is the size of your organization(s) as indicated by the current average inpatient/resident census? (1993 question) What is the current average inpatient/resident census of your facility? Indicate facility type. (2006 question)

Responses to this question varied as much as does the ministry itself. Some persons serve in facilities of well under 100 beds (one participant in the focus group works with several small hospitals, none larger than 50 beds), while the majority served in facilities of over 250 beds. The variety of respondents—they ranged from senior vice presidents in some of the nation's largest health care delivery systems, on one hand, to directors of mission in small, rural hospitals, on the other—

accounts for the variety of responses. Interested persons can find the exact breakdown on the Mission section of CHA's website, www.chausa.org.

By percentage, indicate the current allocation of your time in a mission role.

This is another question in which the answers do not have arithmetic consonance. When one adds up the percentages in the 1993 survey, one arrives at a sum of 117 percent. I am not sure exactly what this means, but it may well indicate that the early mission leaders felt that their time and expertise was stretched and challenged.

However, according to both the 1993 and 2006 surveys, mission leaders spend more than 18 percent of their time in administrative and executive meetings. Interestingly, pastoral care takes 12 percent of mission leaders' time; social accountability takes another 10 percent. Given the current internal and external focus on social accountability, one can expect the latter percentage to increase. In many cases, the mission leader is expected to be a Jill- or Jack-of-all-trades—his or her time and expertise is spread across a broad range of interests and commitments.

What is your relationship to the ethics committee in your organization?

The ethicist role was inaugurated in Catholic health care at approximately the same time as the mission leader role, in the later 1980s. But the two roles have developed in quite different ways. In part because of the ethicist's rigorous and lengthy academic preparation, there are fewer ethicists than mission leaders. As a rule, only very large facilities have a designated ethicist. Individual facilities usually rely on ethical consultation services from systems or from part-time ethicists. In many systems, the ethicist has a direct reporting relationship to the vice president of mission.

That being said, in 1993, 58 percent of the responding mission leaders were members of an ethics committee, although only 22 percent served as an ethics chairperson. Today, 28 percent of mission leaders are members of their ethics committees; 28.3 percent of mission leaders serve as the committee's chair. Struck by the similarity of the 1993 and 2006 responses, we raised the issue in the focus groups. Those discussions revealed that, in many cases, the mission leader is the "responsible staff person" for the ethics committee (responsible, that is, for convening meetings, making sure that minutes are taken, etc.), while a nurse manager or physician is likely to be the committee's official

"head." What is quite clear from the focus group responses is that the functioning of the ethics committee varies from system to system and from institution to institution.

Does your organization employ an ethicist?

Interestingly, the 1993 and 2006 responses are the same—59 percent of respondents said their organizations did not directly employ an ethicist. However, more than 60 percent said their organizations do employ the services of an ethics consultant.

Are you responsible for the ethics function within your organization?

Currently, 67 percent of mission leaders are responsible for the ethics function in their organizations. The question thus arises: If the ethicist does not report to the mission department, then where *does* he or she report? In some cases, the ethicist may report to the senior vice president of medical affairs, in which case the ethicist's attention will be focused strictly on clinical ethics. Among ethicists, there is some question as to job expectations, reporting relationships, and ability to judge efficacy when the person to whom the ethicist reports may not have the expertise to understand or judge the position's scope. We will speak of this again when addressing job preparation and competencies for the mission leader.

Is your organization involved in continuous quality improvement (CQI) or total quality management (TQM)?

This question was asked in 1993 because TQM was still fairly new then. Currently, 93 percent of Catholic systems are involved in CQI or TQM. The question remains: *How* is the mission leader involved in this organizational process?

Does your organization have a leadership development/formation program?

In the 2006 survey, 81 percent responded affirmatively; the 1993 response was 68 percent. As with the previous question, the relevant question concerns the *extent* to which mission is involved in program development, delivery, and evaluation.

Has your organization been involved in collaborative meetings with other hospitals/organizations in your community?

In 1993, many free-standing hospitals were forming systems because of the rapid expansion of managed care. In some cases, the mission department was not as involved as one might hope in the initial due diligence between organi-

zations. This question addressed that concern. In 1993, 89 percent of organizations were engaged in some type of collaborative meetings. In 2006, the number had decreased only slightly, to 82.4 percent.

Does your organization have a joint venture or a merger plan with an other-than-Catholic organization?

In 1993, joint venture and merger plans with other-than-Catholic organizations were emerging as part of integrated delivery networks. Mission leaders and corporate ethics committees attempted to address the Catholic identity challenges these relationships posed. That year, 39 percent of respondents noted that their organizations were engaged in such ventures, whereas in 2006 the percentage had climbed to 51 percent. Most systems and institutions have now developed decision-making tools, policies, and procedures to ensure that Catholic identity is preserved as they enter into these transactions.

SOME NOT-SO-FINAL THOUGHTS

A comparison of responses to the 1993 Mission Leaders Survey with those of the 2006 version shows tremendous advances in the field. More people now serve as mission leaders throughout the ministry, in everything from system offices to small, rural hospitals, and including managed care offices. Although more women religious serve in this capacity than did in 1993, laypersons almost equal them in number. Even a limited prognosticator could safely foresee that the number of laity will increase rapidly over the next five years. Many vice presidents of mission who once worked alone are today assisted by mission directors, evidence of mission integration's advance throughout large organizations.

Some responses to the new survey indicate a need for closer examination. For example, although oversight of operations may give a mission leader credibility within the facility, it could also serve to draw him or her away from the primary purpose of the mission leader role. Another sensitive issue is that of the mission leader reporting to the CEO. In some cases, the CEO is so busy that he or she does not have sufficient time to adequately supervise a large number of direct reports. On the other hand, reporting to another executive can send a message to the organization that the mission leader role is not necessarily primary to decision making. It can furthermore "screen" the voice of the mission leader to the CEO, and vice versa, often mitigating the message.

In the September-October issue of *Health Progress*, we will discuss the remainder of the 2006 survey, examining mission leaders' educational preparation, compensation, and succession planning. We will explicate further the implications of the results as gleaned from the focus groups.

Contemporary mission leaders—like the early Christians Prisca and Aquila—labor with and for the healing ministry as disciples, fellow workers, sacrificing friends, and wisdom figures. With the apostle Paul, the ministry should "salute" them and "give thanks" for the gifts they share for the common good. ■

NOTES

1. Mary Kathryn Grant, "Mission at the Millennium," *Health Progress*, March-April 1999, pp. 18-20. In The Acts of the Apostles, Prisca is called Priscilla.
2. See Joanne Turpin, *Twelve Apostolic Women*, St. Anthony Messenger Press, Cincinnati, 2004.