

2006 CHA MISSION LEADERS SURVEY 2

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

In this second article of a two-part series on a 2006 survey of mission leaders in Catholic health care, Sr. Patricia describes the survey's results concerning education, qualifications, experience, compensation, and benefits. In the first article, published in the July-August issue, Sr. Patricia shared results concerning organizational information and the mission leader's role in senior management.

In the July-August *Health Progress*, we reflected upon the early Christian wife and husband, Prisca and Aquila, as prototypes of health care mission leaders (Acts 18, Romans 16:3, 1 Corinthians 16:19). These first-century ministers were converted to Christianity in Rome, met Paul in Corinth, and then traveled with him as he set out on another missionary journey. Having responded to Christ's call before they encountered Paul, they welcomed him into their home and hearts, sharing their resources with him for 18 months. In a real sense, this time spent with Paul was what we would today call a mentoring or formation period of their lives. Already on fire with the love of Christ, they grew in wisdom, zeal, and commitment. The couple accompanied Paul to Ephesus and continued to spread the Good News of Jesus' life, death, and resurrection.

One could argue that their time of formation and preparation equipped them for both their ministry and the leadership role they played in guiding the nascent Christian communities (Acts 18:26). CHA's 2006 Mission Leaders Survey demonstrates that today's health care mission leaders are, like Prisca and Aquila, increasingly well prepared to assume the leadership roles to which they have been called. Today the position is, for the most part, recognized for the vital,

professional role it plays in any senior health care team. This second article reveals the development in education, compensation, and benefits of contemporary mission leaders. It highlights some possible implications of the survey itself and looks to strategic planning for future mission leaders.

SURVEY BACKGROUND

As we said in the first article, 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 essential 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, and representing long-term care, acute care, and various 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 qualities and competencies they should be looking for in a mission leader. They frequently ask whether there is a ministry norm. Questions commonly asked are "What kind of preparation or experience is needed?" "How much should we pay?" "Who should report to the mission leader?" and "Can or should 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 peo-

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ple'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 expectations of) the position were not very well established. Today we believe (and the 2006 survey attests to the fact) 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 within their respective organizations. They also reflected upon its broader implications for Catholic health ministry. In offering the survey's results in this article, I will include a 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 of the portion of the survey relating to qualifications, competencies, and compensation, I must again 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 regard to system, region, or facility level. Information provided by those who accessed the survey was placed into a single folder. 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. Furthermore, discussion within the three focus groups has already highlighted the need to make significant changes in the next survey. Noting that the mission-leader role has changed significantly in the past 12 years, participants suggested that CHA consider such a survey every five years.

QUESTIONS AND RESPONSES

Please check the category that describes your highest level of education. Please check the category that best describes your area of specialization.

As the role of mission leader emerged in the late 1980s, it had no specific requirements concerning competencies or education, although most persons who assumed the role were "seasoned" individuals possessing the necessary experience, education, and gravitas to effectively take on the responsibilities entailed. Respondents to the 1993 survey filled this question out differently than did the 2006 group. They simply checked all of their degrees, including bachelors' and graduate degrees. For the most part, the largest number of persons had masters' degrees in the fields of education, theology, and nursing, with a few having degrees in spirituality.

In the late 1990s, CHA's Mission Leaders Committee, in dialogue with various system mission leaders, developed a list of desired competencies (available on CHA's website). Recognizing that many individuals move to mission leadership from another professional role, they worked to define a body of basic educational and (particularly) theological knowledge that, if they possessed it, would assist future mission leaders and help ensure their success. At that time, some schools of theology and/or ministry developed programs specific for the preparation of current and future mission leaders.

The 2006 survey clearly reflects these efforts. The majority of respondents (82 percent) have completed graduate-level degrees. Broken down, survey results show that nearly 14 percent have earned doctoral degrees and 68 percent master's degrees. Nearly 8 percent responded that a bachelor's degree is the highest level of education achieved.

Concerning areas of expertise, 114 of the 225 who responded to this question said she or he had some proficiency in theology. These numbers are somewhat difficult to interpret because respondents were allowed to choose more than one area of expertise. It is important to note that there was no breakdown for subcategories of biblical, systematic, pastoral, or moral theology. "Theology education" drew the highest number of responses and "ethics" received the second-highest, although the survey did not enable respondents to stipulate whether in this case "ethics" meant ethics certification or a significant number of graduate courses. Areas of expertise with significant response rates included "formative spirituality," "counseling," "organizational development," "health administration," and "nursing."

Although the survey did not allow participants to indicate whether they had dual master's degrees, the field is seeing a growing number of mission leaders with them, further equipping them for the challenges of their current ministry. Notable among these dual degrees are joint master's in divinity and ethics, theology and business administration, and organizational development and theology. While the evidence is anecdotal, having been gathered during the focus groups, one gathers that many women and men, growing in experience in the mission leader position, are intentionally honing their professional skills to become even more effective in their positions.

Whereas these responses provide insight into the qualifications today's mission leaders bring to the position, the next question's responses might offer greater insight into the evolution of the role.

Please rate the graduate academic field(s) that would be most beneficial for a person in your position. (The scale was 1-4 with 1 being "not beneficial" and 4 being "very beneficial.")

In 1993, the top four fields (ranked highest to lowest) were theology, ethics, spirituality, and ministry. This year, the ranking differed in that ethics was highest, followed by spirituality, ministry, and theology. The fields seen as having the least direct benefit were social work and business administration.

Why would theology shift from first to fourth in ranking? Why might business administration be one of those ranked lowest? These questions might get to the heart not just of the evolution of the mission leader role but also of the organizational changes our systems and institutions are experiencing. I will offer some personal as well as reviewer interpretations of several of the topics mentioned above.

The fact that theology moved from first to

fourth in the ranking could reflect some trends that we see in the larger society. A survey of popular literature or even a quick perusal of the internet reveals a growing fascination with spirituality in all aspects of life, but particularly in relation to the health of individuals, families, and communities. In many cases, this new interest takes the place of a more formal practice of religion.

Furthermore, the growing pluralism of race, ethnicity, and religion in the United States sometimes results in a kind of syncretism, substituting "spirituality" for the rites and rituals of distinctive faith traditions. Given the clarity of the spiritual and pastoral care section of the U.S. Conference of Catholic Bishops' *Ethical and Religious Directives for Catholic Health Care Services*, this trend could be challenging for those who assume leadership of a church ministry. Some focus group respondents provided another interpretation, noting that many mission leaders already have solid educational grounding in theology and may now desire to continue to study those areas in which they believe they need further professional expertise.

Whether this shift is positive or negative remains to be seen. However, because Catholic health care is an official ministry of the Catholic Church, it is the responsibility of the mission leader to be well-grounded in an understanding of, and appreciation for, the theology upon which this ministry rests. The role of the mission leader demands that he or she will frequently relate to church leaders (often of different denominations). She or he will be called upon formally and extemporaneously to articulate the meaning and understanding of a multitude of hospital and organizational practices—ranging from welcoming volunteers to praying with emergency room staff to explaining a layoff. Absent a solid grounding in theology, a serious danger exists in that the mission leader's words and actions may not adequately reflect the richness of our Catholic tradition.

The emphasis upon ethics may reflect the practical day-to-day experience of mission leaders, particularly those within facilities. Some academics consider ethics a branch of "practical theology." It is certainly theology-in-action and is reflected not only in challenging clinical ethics cases but also in the everyday corporate decision making that is part and parcel of the work of senior health care teams.

One focus group participant noted that she held three degrees: one in theology, one in business administration, and still another in nursing. She observed that "the degree I get the most mileage out of is my nursing degree." She cau-

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tioned that facilities and systems would be wise to look to clinical leaders who happen to “get the mission” in order to develop and call forth mission leaders for the future.

Furthermore, one “seasoned” system mission leader advised, there are three areas to consider when hiring a mission leader: education and/or preparation, competencies, and character. The third element is one that cannot be emphasized too much. An individual may have several advanced degrees and an extensive curriculum vitae, but there is another, almost indefinable attribute that makes or breaks the mission leader. Whether one calls it an “expressed spirituality,” “integrity,” or “credibility,” it marks the difference between an individual who can function in a job and one who can truly lead and inspire others to the mission of Catholic health care.

Please rate on a scale of 1 to 4 the following qualifications and skills according to their importance for an organizational mission person.

In any field of endeavor, an advanced degree does not guarantee success. This is certainly true in the role of mission leadership. Survey respondents were asked to rank what they considered necessary qualifications and skills. (Here the reader might wish to refer back to “2006 CHA Mission Leaders Survey 1,” p. 48, which reports respondents’ attempts to calculate how they spent their time each day.) By far, the greatest amount of time was spent in business or administrative meetings. The following responses and ranking reflect this reality. The survey listed 20 various qualifications and skills, ranging from “administrative skills” to “public speaking skills.” Of suggested skills, participants ranked highest:

- Ability to work well on a team
- Good oral communication skills
- Group facilitation skills
- Knowledge of business practice
- Labor relation skills
- Written communications skills

Qualifications and skills ranked by participants as less beneficial were:

- Membership in the sponsoring body
- Organizational development skills
- Experience in health care

Again, when referring to “2006 CHA Mission Leaders Survey 1,” one sees that, whereas in 1993 many mission leaders were members of sponsoring congregations, today this is no longer the case. Furthermore, several focus group participants noted that they had successfully moved from other ministries into health care by utilizing excellent mentoring in health care. One person who had filled out the 1993

survey observed that she did not then think she needed skills in organizational development. However, as health care has grown and become more complex, and she herself has deepened in experience and understanding, she has come to believe that an understanding of organizational development is necessary for the success of any mission integration program.

Please select the range that most accurately reflects your base annual salary.

CHA asked this question in 1993 and again in 2006, for several important reasons. The committee wanted to gather data for a baseline of salaries, even though it recognized that facility or system size, market variables, and position title can cause marked differences in salary range. (Survey respondents ranged from mission directors at small rural hospitals, on one hand, to senior vice presidents of mission at some of the country’s largest systems, on the other). Salary range can and often does indicate the level of professionalism of the individual, as well as whether and how much the organization values that particular position. If the mission leader is to sit as one among equals on a senior team, and if a system requires that she or he is fully qualified for such a role, then distributive justice demands that the salary scale be commensurate with that of other senior leaders.

In 1993, 13 percent of respondents made less than \$35,000, whereas in the 2006 survey only 3.6 percent selected that bracket. In the previous survey, the largest percentage of respondents (21 percent) reported their salaries as between the \$50,000 to \$60,000 range. In this year’s version, however, only 6.3 percent of participants selected that range. In 2006, a large (16.3 percent) number of mission leaders reported salaries in the \$70,000 to \$80,000 range, but the largest number (nearly 27 percent) reported that they made between \$100,000 and \$150,000. Another 9 percent said they earn between \$150,000 and \$199,999. A \$200,000-and-over category was added to the 2006 survey because several 1993 respondents had said that version had no salary category high enough for them to select. In 2006, 5.4 percent of participating mission leaders selected the \$200,000-and-over range.

It is important to remember that, concerning this specific question, we did not ask about the size of the facilities involved or about the number of direct reports to the mission leader. Because consideration of such factors would greatly enhance the relevance of the results, we hope to inquire about them in the next survey of this group.

Do you receive the same benefit package as do staff on a comparable level in your organization?

This question speaks to the history of the position—particularly in relation to the time when this job was held largely by religious women. Of the 219 responses in the 2006 survey, 192 selected “yes” and 27 choose “no.” This is an increase in “yes” responses of nearly 3 percent from 1993, when 85 percent said they received the same benefit package.

In some cases, particularly prior to the 1990s, members of the sponsoring religious congregations did not necessarily get paid a “professional salary.” Those congregations may have considered their ministry “donated services.” By and large, that is not the case today. Not only have congregations recognized that justice demands that their members receive professional salaries in order to help support the congregation, but true succession planning recognizes that positions now held by religious will more than likely be filled by lay persons. However, in the 2006 survey, 12.6 percent of respondents continue to receive smaller benefit packages than others in their organiza-

tions. Some focus group participants opined that this disparity may signify areas of the country, particularly the Northeast, in which health care is experiencing serious financial duress. In that region, some women and men religious voluntarily continue to serve without the same compensation benefits received by their peers, simply to help ease the financial restraints upon their institutions. One recognizes that this type of sacrifice, although laudable, is not sustainable over a significant period of time and could seriously hinder future recruitment of mission leaders.

Please indicate other benefits paid by your employer (that you receive as part of your employment).

The scope of these offerings changed significantly in the 13 years between surveys. In 1993, benefits cited included car, housing, car phone, investments/annuity, professional dues, and incentive bonuses. In 2006, they included car, cell phones, conference fees, housing, incentive bonuses, insurance premiums, investments/annuities, professional development, and professional dues.

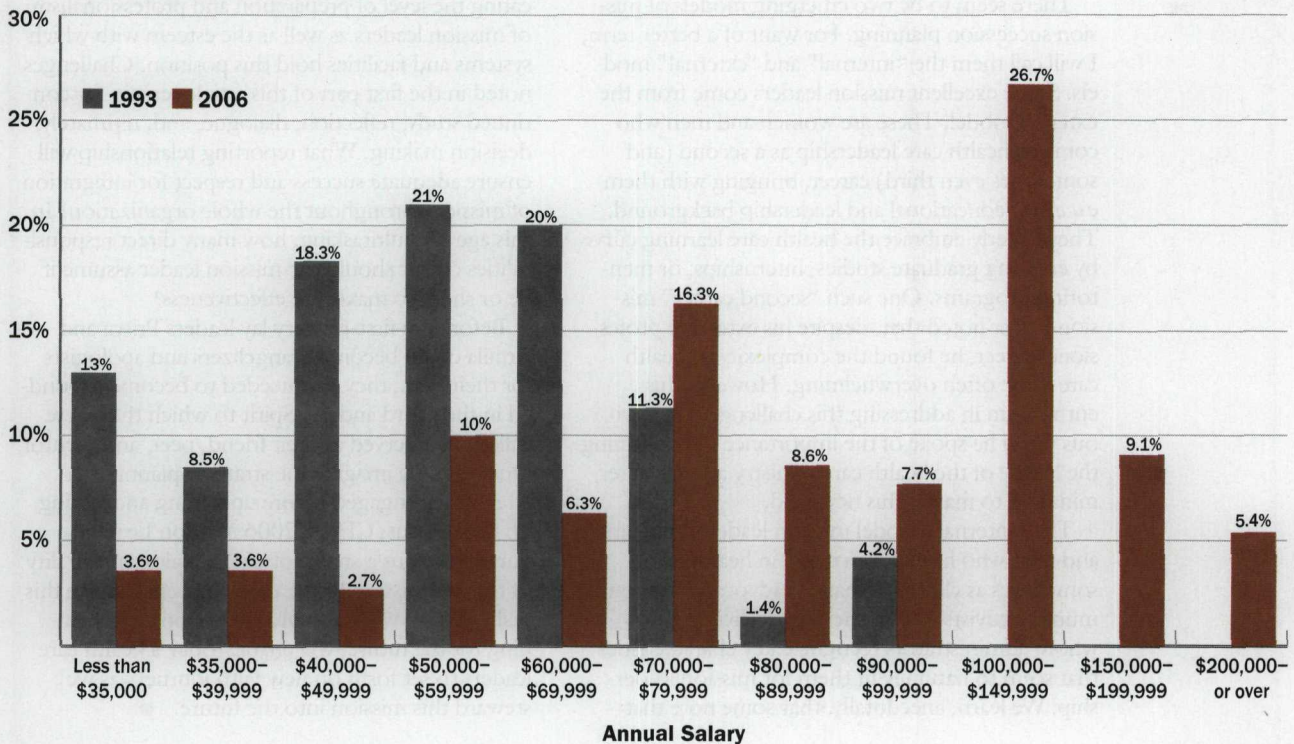
Mission Leader Salaries

1993

Please check the range that best reflects your base annual salary (excluding any incentive or bonus pay).

2006

Please select the range that most accurately reflects your base annual salary.



Discussion of this topic highlighted the fact that, while “perks” like car and bonuses are certainly appreciated, participants especially valued help with professional development and professional dues because these benefits contribute to their ability to perform at maximum benefit to the ministry. One focus group had a lively discussion about the ethics of incentive compensation directed to senior teams alone. Although this is certainly an important and challenging topic, it is one that requires study and reflection for another time.

SUCCESSION PLANNING

Even though neither survey asked about succession planning, all three focus groups addressed it in detail, for obvious reasons. The ministry is keenly aware that the mission-leader workforce is becoming more “vintage.” This undeniable fact is both a blessing and a challenge. With age comes experience and, hopefully, wisdom. The Catholic health ministry has, over the years, been wise in recognizing wisdom figures and looking to them for guidance and direction. The challenge to the ministry is the fact that, in the area of mission leadership, there has been inadequate and spotty succession planning. “God will provide” may be a faith-filled axiom, but it should not be taken to mean that trustees and sponsors can abdicate their responsibility for intentional succession planning in this most vital of roles. Because of the importance of succession planning, this will be an area that CHA will survey in the future.

There seem to be two emerging models of mission succession planning. For want of a better term, I will call them the “internal” and “external” models. Some excellent mission leaders come from the external model. These are women and men who come to health care leadership as a second (and sometimes even third) career, bringing with them excellent educational and leadership background. They eagerly embrace the health care learning curve by entering graduate studies, internships, or mentoring programs. One such “second career” mission leader noted that, despite his extensive professional career, he found the complexity of health care to be often overwhelming. However, his enthusiasm in addressing this challenge was obvious when he spoke of the importance of continuing the legacy of the health care ministry and his determination to master this new field.

The “internal” model mission leaders are women and men who have “grown up” in health care, sometimes as clinicians, patient advocates, or community activists. Often these are individuals in whom administrators recognize key characteristics that seem to naturally fit them for mission leadership. We learn, anecdotally, that some note that

they were literally “called” by a CEO, mission leader, or sponsor and asked to consider serving their organizations in such a capacity. The learning curve for these persons is that of theology and ministry, and many of them have entered graduate programs to complement their already-recognized skills.

In a few large systems, a third model seems to be emerging, one that weds the “internal” and “external” models. Some system mission leaders are appealing directly to young persons currently enrolled in ministry programs in Catholic universities and schools of theology, inviting them to consider health care leadership as a ministry of the church. Unfortunately, even with increased collaboration between Catholic health care and Catholic higher education, the possibility of a career in Catholic health ministry has yet to capture the imaginations of these potential future candidates. Those who do enter health care directly from graduate programs acknowledge their need for broad experiences and careful mentoring. The knowledge, commitment, energy, and creativity of those who have made this leap indicate that this is a rich, if still relatively untapped resource.

A WORK IN PROGRESS

Even a quick perusal of the preparation of today’s cadre of mission leaders reveals that they are every bit, if not more, academically prepared as their senior leader peers. The marked change in compensation for this position exceeds market rises, indicating the level of preparation and professionalism of mission leaders as well as the esteem with which systems and facilities hold this position. Challenges noted in the first part of this article remain for continued study, reflection, dialogue, and, ultimately, decision making. What reporting relationship will ensure adequate success and respect for integration of mission throughout the whole organization? In this age of multitasking, how many direct responsibilities can or should the mission leader assume if he or she is to maximize effectiveness?

Before the first-century lay leaders Prisca and Aquila could become evangelizers and apologists for their faith, they first needed to become grounded in the Word and the Spirit to which they were called. Paul served as their friend, peer, and mentor. One can only imagine the strategic planning in which they engaged before uprooting and setting off to Ephesus. CHA’s 2006 Mission Leader Survey gives us a snapshot of the reality and vitality of today’s mission leader role. Reflection upon this reality, along with careful and collaborative planning for the future, will enable today’s health care leaders to set forth on new faith journeys as we steward this mission into the future. ■