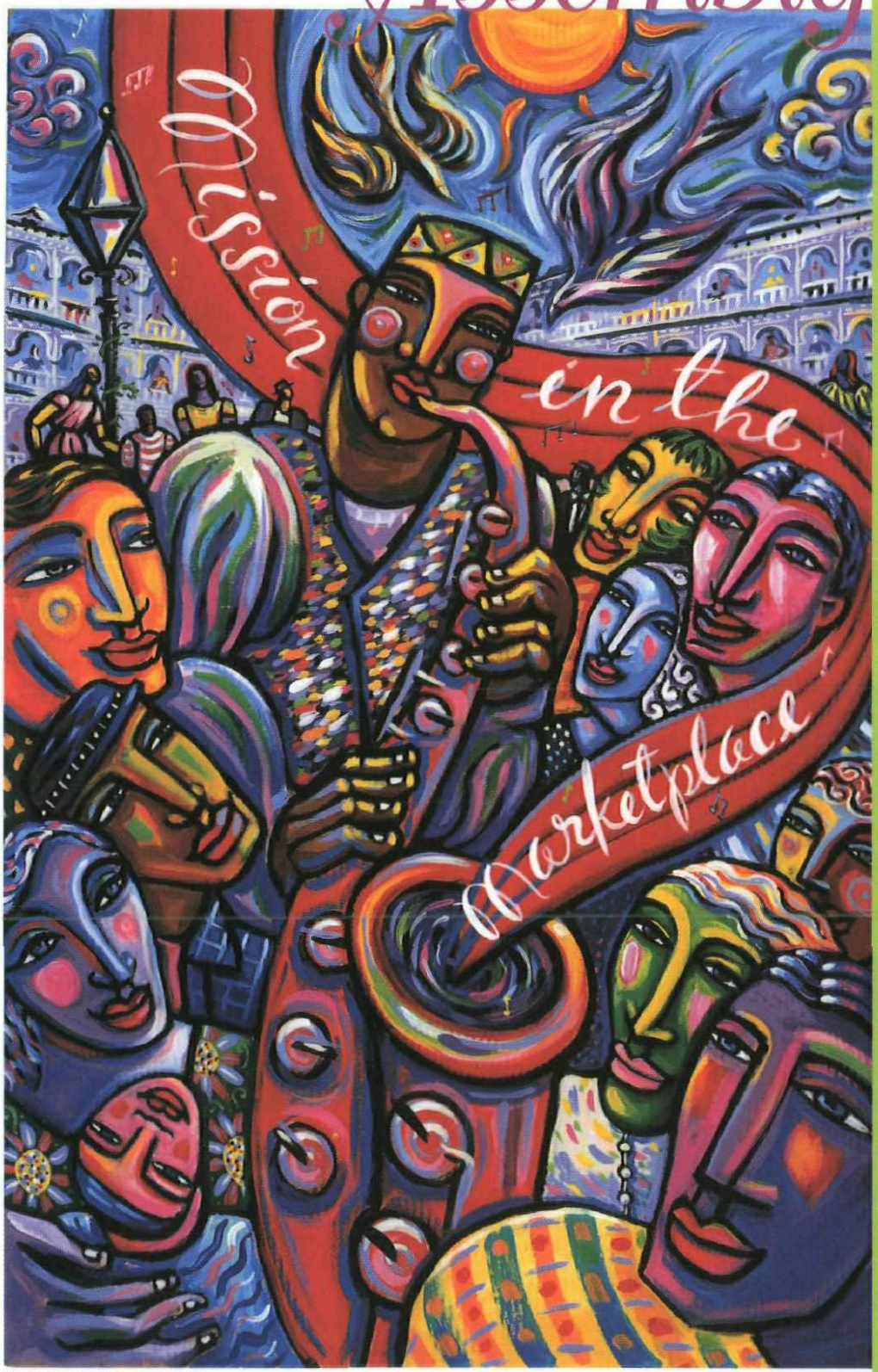
83rd Catholic Health Assembly



Illustrations by Elizabeth Rosen

June 7 -10, 1998

In a city that rose from the Mississippi delta in 1718 as a gateway to the world's markets, more than 1,500 people met to examine our Catholic health ministry's role in today's marketplace. The record attendance at the Catholic Health Association's (CHA's) assembly in New Orleans was a vibrant affirmation of participants' commitment to the ministry. Responding to the theme "Mission in the Marketplace," they demonstrated their determination to not only understand the ministry's place in the marketplace but also to transform the marketplace in order to serve people better.

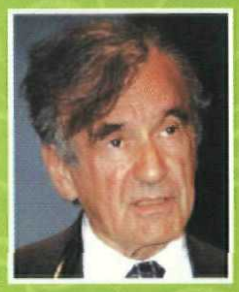
From beginning to end, the assembly addressed contemporary challenges. Keynoter Elie Wiesel and Wednesday's final speaker Doris Kearns Goodwin inspired the assembly audience with their historical perspectives on serving society's most vulnerable and on identifying leaders to guide the ministry into the next millennium.

Educational sessions focused on other vital issues facing the Catholic health ministry in a competitive, pluralistic environment: partnerships, managed care, maintaining integrity, long-term care, attending to the spirit, and public policy.

In the following pages, we summarize some highlights from the conference. To get more information, you may obtain audiotapes (see p. 81) or contact CHA.

Wiesel Urges Ministry To Fight Indifference

An Auschwitz survivor says societies are judged by how they treat the vulnerable.



Elie Wiesel

Members of the Catholic healthcare ministry must vigorously oppose indifference by continuing their mission to help the weakest members of society. Elie Wiesel, winner of the Nobel Peace Prize and survivor of two Nazi death camps, put forth that challenge in the keynote address.

One of only 400 children who survived Auschwitz, Wiesel said the first obligation of a moral society is to be responsive to the hurting of others. "To be blind to others' anguish is to be inhuman." Society will ultimately be judged by how it treats those who suffer, including its children, the homeless, the jobless, and the sick, he said. That responsiveness begins within each person. Morality can only be taught by example. "I have no right to teach you to be moral unless I am moral myself," Wiesel said.

> The first obligation of a moral society is to be responsive to the hurting of others.

Health is a major component in the makeup of a moral society, Wiesel said, lauding assembly-goers for their roles in providing care to the sick. "Society will be praised or blamed for its relationship to the sick" because all life is irreplaceable and unique, he said. Wiesel asked the audience to remember three groups of people who need their help: children, elderly, and those who make us feel helpless, such as the severely disabled or persons with Alzheimer's disease.

Wiesel questioned whether society, which is responsible for providing children's basic needs—food, shelter, education, and love—actually does enough for them. Children have been lured into street gangs, tempted by drugs and crime, and given easy access to weapons. They are seduced by off-the-mark values that tell them it is all right to make fast money and to acquire power—no matter what the cost to others, Wiesel said.

Wiesel urged that compassion for children not be limited to our own country; it must have a global viewpoint. Every 60 seconds, hunger, violence, and disease claim the life of a child somewhere in the world, he said. "I plead with you. Let us not say they are not our children. In a moral society, all children are our children," Wiesel said.

The elderly also need special attention because modern society "is too busy worshiping the culture of youth" to value them, Wiesel remarked. He said our culture makes the elderly feel discarded, humiliated, and ashamed. Society hides its fear of aging by inventing euphemisms such as "senior citizen" and "the golden age," according to Wiesel.

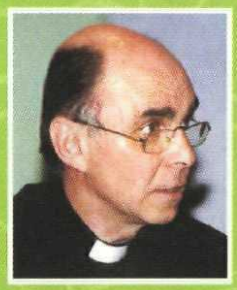
This fear is a stark contrast to ancient times, when the elderly were respected and wisdom was synonymous with old age. As an example, Wiesel pointed to ancient Rome, where older senators were sought out for their advice. "Scripture commands us to respect the aged," he said. Instead of ignoring the needs of the elderly, Wiesel said, people should consider it a privilege to extend a helping hand to them. "Why does our society try to do so much for children but so little for the old?" he asked.

Wiesel also called for compassion for those in society who make us feel helpless, citing children with severe disabilities and people with Alzheimer's disease as two examples. Because these groups ultimately have no future, caring for them is "an act of pure selflessness," he said.

Although society cannot always cure people's illnesses, Wiesel said, caregivers can ease their solitude and bring solace to those who have none. "It is you and people like you who introduce morality into our society."

Healthcare Marketplace Called Morally Blind

A theologian urges Catholic healthcare workers to remember that their vocations transcend economics.



Rev. J. Bryan Hehir, ThD

As Christians must be in the world but not of it, Catholic healthcare organizations must be in the marketplace but not of it, Rev. J. Bryan Hehir, ThD, told assembly-goers.

Indeed, said Fr. Hehir, a professor at Harvard Divinity School, Cambridge, MA, he at first had some trouble writing his assembly address—about ministry in the marketplace as a necessary evil or an opportunity for good—because he knows relatively little about healthcare economics. But then, he said, he realized that the main issue involved was theological rather than practical. "It is the issue I find precisely at the Catholic heart of the mystery of things," he said. "It is part of the larger question of the Church and the world."

Fr. Hehir said Catholic theology sees the world as having three aspects: as cosmos; as threat to human power; and as theater of human activity. God, the "architect of the cosmos," has engaged in "an enormous gamble" by making humans the world's stewards, Fr. Hehir said. "God gives us the world, but, to use the language of John Paul II, there is a 'social mortgage' on it. We are to perfect the work of God and will be judged accountable for it."

It is this huge moral drama that makes humanity's adventures in the world theater, Fr. Hehir said. "The world is threat because, as Jesus said, there are powers in the world—and in us—that are not of God."

But, Fr. Hehir continued, we should not fear this drama because God has demonstrated, through the Incarnation, that he will always do his work though humans, that "he will not take back his gamble."

Fr. Hehir noted that the marketplace is but one more stage in God's theater, an episode in his drama. Humans need the marketplace because it can make economic life more efficient. We need such efficiency "because we are not pure spirits." But, like other worldly things, the marketplace is neither entirely good nor entirely evil. "Some aspects of it may be evil enough that we simply have to oppose it. Some aspects may not be good enough to get our full affirmation. And some of it can be supported. The marketplace is an accomplishment filled with ambiguity," Fr. Hehir said.

Although economic questions can be mysterious, Catholics should not stand in awe of them, he asserted. "We do not treat these issues ad hoc. The Catholic vision is prophetic and political. Economic survival is, in itself, never enough when there is a social mortgage on our life."

Jesus took human needs seriously, but he was "radically indifferent to marketplace realism," said Fr. Hehir, citing Jesus' remarks about the lilies of the field who neither toil nor spin. And, according to Genesis, the goods of the earth are for everyone to enjoy.

This is especially true of the goods involved in healthcare, Fr. Hehir said. In 1987 Pope John Paul II reminded Catholics that the marketplace, however efficient, has no moral compass. "In the market, everything is like a Buick," Fr. Hehir said. "But clearly healthcare is not a Buick, and the market is blind to that."

Fr. Hehir said that Catholics working in healthcare should not try to run from the market (since it is part of God's world); indeed, they should never stop trying to transform it (since it is morally blind). Is ministry possible in the marketplace? Fr. Hehir asked. "Yes," he said, "but it is ministry of a particular kind, focused in a major way on those the market leaves behind," the poor and the vulnerable, the uninsured and underinsured.

"Is the marketplace where we ought to be?" he continued. "Yes. Is the marketplace enough for our vision, our life, or our responsibility? No." Catholics can neither be comfortable in the market nor driven from it, he asserted. Acknowledging the fact that we must live with imperfection, Fr. Hehir quoted Albert Camus: "It may not be possible to create a world in which no innocent children suffer, but it is possible to create a world in which fewer innocent children suffer."

New Life in the Inner City

Medical centers in declining urban areas prove that when we "walk with the poor," we get stronger.

Sr. Carol Keehan, DC

Brenita Crawford

Leading by mission—and standing as a sign of hope to both community and employees—is paying off financially for medical centers in two declining urban areas. Sr. Carol Keehan, DC, and Brenita Crawford described how "walking with the poor" has made their facilities stronger.

Often described as a "dysfunctional city," Washington, DC, has a dwindling tax base, too many hospitals, and an underserved population with poor health status, Sr. Keehan said. The health status of its hospitals is not much better. Not too long ago, Providence Hospital was a poster child for ailing urban hospitals everywhere—large losses, no reserves, and a decaying plant. Today the hospital is thriving.

Why the change? "With God's blessings, we made a conscious decision to try to do our mission well," said Sr. Keehan, the facility's president. One of the first decisions was to take the cap off the number of women Providence cared for through its low-income clinic. "We committed to taking all who needed us, picking them up in vans and offering bilingual services," she said. "Our OB numbers soared, and we were able to help the city reduce its infant mortality rate and offer a clear alternative to abortion."

When Providence resisted giving deep, below-cost discounts to HMOs, it saw considerable business leave the hospital. "Had we not expanded our service to the poor, we would have been left trying to support an OB service with 500 deliveries instead of 1,500," Sr. Keehan said. Ironically, those hospitals which gave deep discounts saw their business diminish anyway because of the middle- and upper-class exodus from the city.

Mission also guided relationships with employees. The executive team publicly promised that layoffs would be a last resort and that staff would be given advance notice. "Their appreciation cannot be overemphasized," she recalled. "Staff used their creativity and commitment to strengthen our position in the market rather than watching their backs." Providence became the only hospital in the city without a layoff.

"Those behaviors that flow from our mission are our greatest strength and do more than anything to assure our continued viability," Sr. Keehan said.

Brenita Crawford, until recently the president/CEO of Mercy Hospital, Detroit (and now executive vice president, Methodist Health Center, Houston), described an environment similar to that in Washington, DC, complicated by a merger in the 1970s and several moves. The last move landed the hospital in an area with deteriorating housing.

When Crawford took the job six years ago, she turned mission into the driver for every decision made. "That's what most successful businesses do," she said. "The problem was that in our facility, mission had become synonymous with losing money."

Mercy rewrote its mission statement to convey the idea of "financially responsible" service. Under Crawford's leadership, Mercy has learned to think like a business. Transportation was an issue in getting people to the hospital, so Crawford upped the transportation budget from $200,000 to $600,000 in two years and saw margins increase. "You have to invest to get a return," she said.

Mercy staff reexamined their values and redefined service as a partnership with patients and the community. A series of community focus groups helped clarify for staff how the hospital would need to change.

"We thought people would want free services, but they told us they wanted information and education," Crawford said. "That was a turning point for us." Instead of focusing on sick care, the hospital adopted a health assistance model.

When the state asked Mercy if it would care for prisoners, Crawford agreed, to the dismay of some of her staff. "Now prisoner care is one of our paying ministries," she said.

Managers are expected to spend at least 50 hours a year in community service that is unrelated to their job skills. That commitment has paid off in new relationships. Nearly half of Mercy's new initiatives have been suggested by community leaders, and they've brought grant money with them, she said.

"We've learned that it's important to 'walk with the poor,'" Crawford said. "If you provide service very well, you'll get the paying people too."

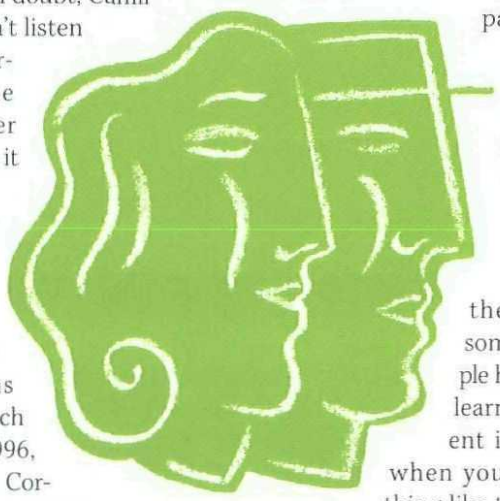
Building Partnerships

System Partnerships Can Aid Both Finances and Mission

Having concentrated its assets, a partnership can help strengthen its weaker members.

"It's vital, in forming partnerships between healthcare systems, that you prove to everyone involved that you listened to them," said Patricia A. Cahill, JD, president and CEO of Catholic Health Initiatives (CHI), Denver. "Leaders must have the gift of listening."

But, because forming such partnerships can be difficult, leaders must be sure to stay positive when others are in doubt, Cahill added. "A good leader won't listen to reasons why a partnership may not work," she said. "Instead, the leader says, Tell me how to make it work.'"



Both Cahill and Gerald R. Pearson, CEO of Provena Health, Frankfort, IL, have helped transform relatively small healthcare organizations into larger ones. CHI, which Cahill helped form in 1996, comprises Catholic Health Corporation, Omaha; Sisters of Charity Health Care Systems, Inc., Cincinnati; and Eastern Mercy Health System, Radnor, PA. Provena, whose formation Pearson aided in 1997, is made up of the Franciscan Sisters *Health Care Corporation, Frankfort; Servant*-Cor, Kankakee, IL; and Mercy Center for Health Care Services, Aurora, IL.

Although system partnerships require much careful work, they can be worth the effort, said Pearson. Provena, which has seven hospitals and 14 long-term care facilities, has strengthened its member organizations both financially and in terms of mission, he noted. "We saved $25 million when we restructured finances. And we now have an improved mission education program for all our employees." Concentration of assets is another advantage of system partnerships, Cahill added. "The strengthened system can use its assets to help its weaker members," she said.

CHI, which comprises 70 hospitals and 48 facilities for the elderly, is sponsored by a dozen religious congregations, said Cahill. (Three congregations cosponsor Provena.) CHI is led by a 14-member stewardship trustee board, seven of whose members are religious and seven are not, that has both civil and canonical roles. In its civil role, Cahill said, the board is responsible to the sponsoring congregations; in its canonical role, "it moves across the hall" and becomes a public juridic person. "This dual role allows the board to act very effectively. We think it may be a good model for the Catholic health ministry of the future."

If she were to participate in the formation of another partnership, Cahill said, she would work harder at involving the boards of the local organizations. Pearson said: "I would get out of the way more and let some of our talented people have a bigger say. You learn a lot about the talent in your organization when you go through something like this, which is another good reason for going through it."

Partnering with Other-than-Catholic Organizations

Forming non-Catholic alliances takes time, careful preparation, and a willingness to be flexible.

A clear sense of identity and carefully articulated goals are hallmarks of successful partnerships with other-than-Catholic organizations, said Roseanne Pajka, vice president, The Lewin Group, Fairfax, VA.

Pajka reported the initial results of a study of four organizations that have engaged in such partnerships: Genesis HealthCare System, Zanesville, OH; St. Mary's/Duluth Clinic Health System, Duluth, MN; Centura Health, Denver; and Catholic Healthcare West, San Francisco. The final

Patricia A. Cahill, JD

Gerald R. Pearson

Roseanne Pajka

study results will also include a Daughters of Charity partnership.

Moderator Tim Eckels, senior vice president for planning and policy, CHA, Washington, DC, explained that the study is one of a series of efforts undertaken by CHA to summarize lessons from organizations within the Catholic health ministry for others that face similar challenges. Particularly important, he said, is the question of how to sustain a sense of mission and ministry while moving into partnerships with other values-based organizations.

CHA is also preparing a white paper on the theological rationale for forming such partnerships, explained Jean deBlois, CSJ, RN, PhD, vice president, Mission Services, CHA, St. Louis. The paper, expected to be completed this fall, will consider the Church and the ministry from the theological perspective of Vatican II and will also consider the role of the laity in the light of that council. Findings from the study illustrate the theological rationale, noted deBlois. "The partnerships these organizations undertook are about responding to the needs of their communities, and that's what the ministry is about—it is about response to human need."

Each organization studied faced local environmental pressures that demanded a collaborative response, whether it was the need to reduce duplication and enhance quality, align the hospital more closely with physicians, or increase geographic coverage. But the primary driver behind partnerships in the current economic market, reported Pajka, is the need to cope with the high costs of healthcare. For faith-based healthcare, particularly key is the desire to extend the ministry, as well as to secure it for the future.

> Partnerships create an added layer of complex leadership issues. -Roseanne Pajka

Most of the preliminary lessons from the study involve communication, which Pajka called key to dispelling myths about Catholic identity. All the organizations studied had implemented extensive and innovative communication strategies, including newsletters, videos, and continuous updates.

Sr. Doris Gottemoeller, RSM

Business Meeting Outlines CHA's New Directions

CHA is an organization that "has a firm sense of direction, is engaged with its members, and has a blueprint for action on behalf of the ministry," Sr. Doris Gottemoeller, RSM, told the membership assembly in her address as CHA's newly elected board chairperson (see also p. 10). Reflecting on the assembly theme, Sr. Gottemoeller noted that "we are, as a ministry, distinctive in mission. We also want to be distinguished in the marketplace."

CHA's 1998-99 strategic plan (p. 93) will serve as a blueprint for working with members to add value to the work of systems and "enhance and build on our independent actions as ministry," she said. In one initiative, the New Covenant cosponsors—CHA, the National Coalition on Catholic Health Care Ministry, and Consolidated Catholic Health Care—are holding focus groups across the country to determine whether and how to proceed with the development of a shared ministry vision. Such a vision, Sr. Gottemoeller said, "will help us ensure that we are distinguished—distinguished in what we do for the poor and sick, distinguished in how we advocate for a more just and compassionate healthcare delivery system."

Membership and Dues

Members approved changes to CHA's membership and dues structure, reflecting the move toward integrated delivery and the growing importance of healthcare systems and diverse partnerships. As of July 1, 1999, the association will reorganize membership around systems; open membership to non-Catholic entities that are controlled and recommended by CHA representative members; and institute a single, lower dues rate that will apply to all systems and freestanding facilities that are representative members. "The plan is budget neutral for CHA in the first year," explained outgoing board chairperson David Lincoln. "In future years, the board is committed to holding any increases in CHA's operating budget to the consumer price index." (For more information, contact CHA's Chief Financial Officer Brian Carney or CHA's General Counsel Peter Leibold, or see Catholic Health World, June 15, 1998.)

Involve your bishop "early and often," and engage in an explicit process to articulate your self-identity, Pajka said. "Partnering may force this issue for you," she noted. It is also important to articulate the breadth of Catholic identity. "Don't let other people define you," Pajka warned, since their conception of Catholic identity and healthcare may be limited.

She told participants to find common ground with partners, such as values of compassion, trust, respect for the patient, innovation, and excellence, and to carefully manage service configuration issues, because they will be highly visible. Consolidation of services may promise cost reduction and higher quality, she said; however, these changes have the potential to be "deal breakers." Early, open, and specific discussion of options is critical, and must involve staff and physicians, reported Pajka.

Be prepared for extensive work on organizational culture as well as for upheaval in both organizational and personal relationships, she said. Most interviewees at the organizations studied reported that they had underestimated the importance of understanding cultural similarities and differences, and the organizations are increasing their efforts to look closely at cultural characteristics.

Partnerships create an added layer of complex leadership issues, Pajka added. Leaders must deliver honest and consistent messages as well as be champions for the partnership. Leadership issues that continue to be addressed during implementation of the partnerships included the role of local boards and the partnership board, the roles of the CEOs and board chairpersons, and the role of evolving sponsors or new cosponsors.

Accept that the process will take time, Pajka advised. "Have a sense of peace about it," she urged, and draw on the collective experience that develops as you move through the process.

Catholic Values, Fair Policies Help Organizations to Gain Physicians' Trust

Respect and honesty influence doctors' decisions to affiliate.

Even though physicians name compensation and quality as their top determinants for choosing partners, when all factors are equal, they prefer partners with a strong values base, according to consultant Wende Fox. Fox, director of APM Management Consultants, Chicago, said that overall, physicians seem to prefer affiliation with a values-based organization. A physician told her: "I sleep better at night knowing that the Catholic hospital will treat the poorest patient, as well as the one with the best insurance."

In general, she said, physicians want to know that they can care for everyone and not worry about how the patient will pay; they want to partner with an organization that has the community's long-term interest at heart; and they don't want stockholders or profit margins to drive the decision making.

When asked directly which factors weigh most heavily when physicians choose partners, respondents overwhelmingly listed economic package first and quality of facilities and services second, Fox said. Only 18 percent of those she has polled named "values" as the reason for affiliating with an organization. However, she said, physicians tend to view a values base as "icing on the cake" when they are well compensated and confident about the quality of facilities and services.

St. Vincent Hospitals and Health Services, Indianapolis, has been successful in incorporating its values into relationships with physicians. Physicians are compensated according to the number of patients they see rather than having patient quotas per payer source. "This is a great example of positive motivation," she said. "Most physicians think it's a great idea. One said, 'I don't want [payer] information that might make me think about making a different treatment decision.'"

Fox's presentation drew on responses from a CHA-hosted physician forum last fall, as well as her own consulting experience. In the uneasy world of hospital-physician relations, not-for-profit leaders reported higher trust levels among physicians than did for-profit executives. One Catholic organization executive Fox worked with said, "Physicians don't trust anyone, really, but they trust us more than our competition because our behavior stems from our value system of respect and honesty."

But Fox has seen trust drop as a new organization grows. "When an organization becomes very large, physicians start to fear their colleagues as well as the organization," she observed. But, she said, Catholic organizations "have a leg up" in terms of using their values to allay fears.

Wende Fox

Leaders of Catholic organizations have less confidence when it comes to developing physician leaders to help carry the mission and values forward, she said. The majority of respondents reported being only somewhat satisfied with progress in this area.

The approaches to partnering with physicians are about as varied as the number of organizations forging such partnerships. The only point of consensus seems to be that no one perfect model exists, Fox said. "I've seen every one of them succeed and fail. Even those organizations going through a difficult time can still point to some pieces that are going well."

Feedback from physicians also indicated barriers in working with Catholic organizations, which tend to be larger and in systems. "The question, is how to streamline decision making," said Fox. Also, the not-for-profit structure can make it difficult for not-for-profits to compete with for-profit equity models and compensation scales. That reality is changing somewhat, she said, as proprietary physician management companies like PhyCor begin to tighten up their compensation scales to get more in line with the market.

Fox said a mistake she commonly sees in her consulting work is an organization exempting physicians from productivity incentives. Physicians must share gains and losses with the network, she said.

In successful networks, Fox said, a group of physicians or a leadership group of physicians and others have authority and responsibility for revenue distribution, clinical management, ambulatory operations, and physician recruitment. She cautioned against a large "House of Delegates" style of governance. The problem with these structures, she explained, is that the physicians feel their responsibility is to serve as representatives of interest groups rather than as leaders of a new organization. A 7- to 10 -member governing board is "the right size for good debate and attendance," she said.

Managing Care and Risk

James J. Unland

National Catholic Provider-Insurer Network Proposed to Restore Public Confidence

A speaker calls on CHA to spearhead a managed care program that addresses consumers' growing fears.

The public and Congress are being bombarded with horror stories about denial of care, physicians fired for providing too many services to patients, and rising healthcare costs, said James J. Unland, president, Health Capital Group, Elgin, IL. The failure of managed care to control healthcare costs and protect patients' quality of care and choice of providers is the topic of daily reports, Unland pointed out, illustrating his assertion with an array of actual television, radio, and newspaper stories.

"The subliminal message," he said, "is that something has to be done." Urged by their alarmed constituents, legislators will pass measures that "amount to nationalized healthcare," he warned, unless a viable model emerges that demonstrates how the private sector can address people's growing frustration.

Unland believes only a strong national effort will be adequate. His answer: A Catholic-sponsored national insurance program that is marketed regionally. Unland believes the window of opportunity to put together this model is very small—about 18 months.

He called on CHA to convene a task force from among CHA members in the next six months. As a start, the task force could guide the creation of a national insurance plan for member employees. "I'm not suggesting all Catholic organizations in the country merge or do all things in the same way," he said. "People could still design products for their own markets, and do regional marketing," he said. But a unified, national effort would provide the necessary resources for the true provider network that Unland envisions.

The national network would assume and manage financial risk for comprehensive health services for a defined population, have a large physician component, make maximum use of noninstitutional settings, create interlinked information systems, and measure outcomes and report them to consumers. The network must differentiate itself

from other HMOs, providing consumer-friendly products that motivate enrollees to join and stay in the plan.

"Not-for-profit Catholic hospitals are uniquely positioned to offer a new approach," Unland insisted. They do not have to pay stockholders and, because of their mission, they have a positive image with the community, he said. "Technically it can be done," Unland said, "but partnering requires the will to do it."

Should Catholic Organizations Form PSOs?

In making the decision, healthcare organizations should evaluate their strategic objectives and assess common pitfalls.

Healthcare organizations have new opportunities to form provider-sponsored organizations (PSOs), but the decision to jump in is complex. While the establishment of Medicare+Choice and federal solvency standards for PSO licensure are paving the way for providers to form risk plans, healthcare organizations should proceed with caution. "Don't do a PSO until you've thought through your strategic objectives," advised Keith R. Anderson, a principal in the law firm of Green, Stewart, Faber & Anderson, PC, Chicago.

Questions to consider, he said, include:

- What are your organization's key strategic objectives?
- What are your core businesses?
- What is the status of commercial and Medicare managed care in your market? "Don't rush into Medicare risk if managed care is low in your market."
- Do you want to be in the HMO business? Anderson reminded the audience that a PSO is really an HMO, noting that a Medicare PSO is an HMO "of the worst caliber" because, under Medicare regulations, members are able to disenroll every 30 days.
- Where will you get the necessary expertise, infrastructure, and financial resources?
- Is this the best use of scarce community resources?
- Is this consistent with your mission?

In addition, providers must be clear on what a PSO is, Anderson said. He defined a PSO as "a public or private entity established or organized and operated by a healthcare provider or a group of affiliated healthcare providers." The providers may be affiliated in a variety of arrangements, including through contract or ownership, he said.

The PSO is required to provide a substantial proportion of the healthcare items and services under the Medicare+Choice contract directly through the provider or affiliated providers, Anderson explained. Affiliated providers must also share, directly or indirectly, substantial financial risk and have at least a majority financial interest in the PSO—maintaining effective control of it.

Also, in order to be a Medicare+Choice PSO, an organization must have either a state license to bear insurance risk or, if it cannot get a state license, a waiver of state licensure from the Health Care Financing Administration. To obtain a waiver, the PSO must be fiscally sound. The application, Anderson said, includes a calculation of minimum net worth and a financial plan that includes, among other documentation, a detailed marketing plan and statements of revenue and expenses. Applicants must also demonstrate they have the financial resources to meet projected losses. PSOs must understand the legal issues in the use of guarantors, including fraud and abuse and private inurement, Anderson cautioned.

"If you're going to make it, you have to avoid common pitfalls," Anderson advised. These include:

- Reluctance to operate as a stand-alone, for-profit business
- Reluctance to reduce provider compensation or terminate providers of marginal quality
- Insufficient provider or geographic access
- Lack of preparation for payer backlash—that is, when a competing HMO terminates the health system from its provider roles
- Insufficient expertise or capital

"Being successful is determined by provider compensation, administrative costs, and utilization," Anderson added. "A lot of big providers have chosen not to get into the insurance business. This is a choice you as a health system need to make."

Keith R. Anderson

Maintaining Integrity

Sr. Beth McPherson, CSC

In Search of a Just Workplace through Dialogue

A technique for deep inquiry and suspension of judgement lets labor and management find common ground.

A new approach to a difficult issue—organized labor in the healthcare workplace—was both modeled for and created by participants in a session on justice in the workplace. Through a process know as Dialogue, the panel members and session participants learned to listen to one another, suspend judgment, and draw on the collective wisdom of the group.

Guided by Sr. Beth McPherson, CSC, an organizational development consultant and trained Dialogue facilitator based at Mission Hospital Regional Medical Center, Mission Viejo, CA, session participants first reflected on the qualities that contribute to good conversation, including respect, trust, openness, and mutuality. Participants in Dialogue create a "container of conversation," a safe environment in which to express views. They also strive to listen together to find common ground; suspend judgment to allow deep inquiry; and balance inquiry and advocacy.

The six panelists, who represented a spectrum of labor and management positions, quickly found points on which they could agree. "It's not about the 'we' or 'they,'" said Thomas F. Schindler, PhD, director of ethics and mission integration, Mercy Health Services, Farmington, Hills, MI. "It's about the patient." The fundamental inquiry that emerged was how to get past the assumption of antagonistic interchange when the question of organized labor arises in the workplace.

"We have to do something to take this sting out," said Mary Kay Henry, assistant to the president of industry organizing, Service Employees International Union, Washington, DC. "Too often a war begins before we have a chance for the dialogue."

Kim Bobo, executive director, National Interfaith Committee for Worker Justice, Chicago, pointed out that labor assumes that management will be hostile toward organizing. "The understanding is, If we tried to organize, we'd get fired." Management literature that decries attempts to organize reinforces this perception, she said. But all on the panel acknowledged that there are two sides to this coin: "It angers management when organized workers exaggerate their wrongs," said Sr. Mary Roch Rocklage, RSM, president/CEO, Sisters of Mercy Health System, St. Louis.

Session participants broke into small groups to discuss and evaluate what they had heard. Sr. McPherson urged them to consider the collective wisdom—the common ground—that emerged from those who spoke and described the real struggle as "the difficulty in moving from entrenched thinking to understanding." If people have a real desire for understanding, she said, "We can work toward the justice we all believe in."

Selecting the Right Leaders Requires "Drilling Down" to Values-Based Behaviors

Leadership selection—rather than education—is critical for the future of Catholic healthcare.

The most neglected aspects of leadership selection, according to John W. Glaser, STD, are the values that shape the person's life. Glaser, who is vice president, theology and ethics, St. Joseph Health System, Orange, CA, said his system struggled for years with how to get beyond the surface to assess the congruence of values between the candidate's values and those of the organization.

"I don't think there is any single thing over which we have control that is as important for the future of Catholic healthcare as the selection of leadership," he said. Organizations tend to think they can educate or mold leaders to their values after they have been hired. "There are conversions," he

said, "but it's not a good principle on which to hang a corporate future."

The selection of a CEO is a time of *kairos*, of growth and opportunity, Glaser said—"a time to revisit who we are and what we are about." He strongly advocated a formal approach to leadership selection to avoid bowing to the urgency of the situation and making a hasty decision.

St. Joseph's leadership selection process looks beyond skills and abilities to the "footprints" left by lived values. The more dedicated a person is to a particular value (such as teamwork or the workplace as an arena for ministry), the more evident it will be in his or her actions, programs, commitments, organizations, theories, and knowledge, Glaser said.

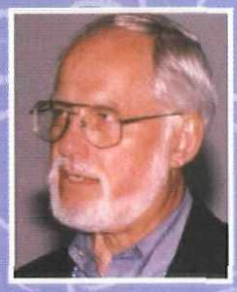
> In looking for leaders, we ask: What do we really need in order to be Church in this millennium?
>
> ~John W. Glaser, STD

To get at these values, organizations first need to define five to eight core competencies (values plus skills/abilities) necessary for the situation. In seeking to replace a hospital CEO, Glaser said, selection teams from corporate and local offices seek input from medical staff, trustees, senior management, and the CEOs of other system hospitals. The groups identify immediate and long-term needs and challenges, both internal and external, and pick (from the system's list) the five most important competencies for the situation.

The selection teams meet to reach consensus on the critical competencies, send the final candidates information on what they are looking for and why, and then interview each of them. "What we're trying to do is get a picture of the relative strengths and weaknesses of each of the candidates on these foundational concerns," Glaser said.

Behavior-based interviewing, he explained, entails knowing what you are looking for and then drilling down into past behavior. "We are not interested in theoretical discussions, hypothetical questions, or discussions of the future," he said. Instead, they spend time reviewing the person's history in relation to the core competencies. Each interviewer uses the same rating scale to "help homogenize our observations" after the interviews.

"The model is one of us first saying, What is it we really need to be in order to be Church in this millennium?" he said, "and then looking for leaders who stand for those kinds of things."



John W. Glaser, STD

Sr. Jane Frances Brady, SC

Sr. Jane Frances Brady, SC, Receives Sr. Mary Concilia Moran, RSM, Award

The work of Sr. Jane Frances Brady, SC, the recipient of the 1998 Sr. Mary Concilia Moran, RSM, Award, embodies the mission of the Sisters of Charity of St. Elizabeth: to work with the poor, alleviate suffering and dispel ignorance, and promote justice. As president and CEO of St. Joseph Hospital and Medical Center in Paterson, NJ, for the past 25 years, Sr. Brady has overseen the development of St. Joseph's into a major regional medical center while maintaining its identity as a community general hospital in Paterson, committed to providing the best possible healthcare for the poor and underserved in the metropolitan and regional areas. Sr. Brady also serves as chairman of the board and executive vice president of the Via Caritas system, the result of a merger between St. Joseph's Hospital and Medical Center with Northwest Covenant Medical Center.

Sr. Brady's efforts on behalf of children have included establishing and serving on the board of directors of the Health Economics and Advancement League Evening Pediatric Center, which cares for sick infants and children in Paterson, fostering collaboration between St. Joseph's and Heal the Children, and leading medical teams to Central and South America to care for children and their families. A tireless advocate for universal healthcare, Sr. Brady was a moving force behind the 1997 passage of New Jersey's "charity care" legislation, which will fund care for the state's poor and underserved.

Long-Term Care

David Sheehan

Managed Care Offers Opportunities for Long-Term Care Providers

For ideas on how long-term care alliances can be structured and improve patient care, two new organizations bear watching.

"Doing business with managed care plans is unavoidable," Jade Gong told long-term care (LTC) providers. Moreover, managed care offers new incentives for LTC providers to form alliances. Especially appealing to Catholic providers are the opportunity to accept risk and earn rewards by managing chronic care, and the chance to innovate to improve care of residents in LTC facilities, said Gong, senior advisor, in the Arlington, VA, office of Health Dimensions, Inc. To date, she said, the formation of alliances has generally been driven by LTC organizations' goal to maintain their profitability by providing services that managed care plans must offer.

Forming LTC alliances for Medicare managed care contracting is a stepping-stone to forming relationships with physicians, hospitals, and others to accept greater degrees of risk, she said. In the next two years, LTC providers will form alliances with managed care plans, hospitals and health systems, physicians and physician practices, and other LTC providers, Gong predicted.

A new managed care option, the 1997 Balanced Budget Act's Medicare+Choice program, also will push LTC providers along. The program will increase payments in rural areas and opens the possibility for social HMOs to serve Medicare beneficiaries. LTC providers are likely to affiliate with provider-sponsored organizations (PSOs), which will contract with Medicare. Such affiliations will require LTC providers to share substantial financial risk with the PSOs' other providers—accepting capitation payment and achieving cost-containment goals, she said.

Connecticut Experience

Anticipating strong growth in Medicare managed care in Connecticut, five not-for-profit LTC provider organizations incorporated in October 1997—in part to compete with investor-owned organizations that were rapidly putting together the infrastructure in multiple locations to obtain managed care contracts. The Fairfield County Long Term Care Alliance—which has since been folded into a 12-organization Connecticut Alliance for Long Term Care—had four "moments of truth," explained David Sheehan, president and CEO of The Hewitt Organization.

The first moment—informal discussions—was "like a support group," he said. Then came the time when the organizations had to pony up the dollars for legal and consulting help to go to the second moment—serious exploration. The third moment—incorporation—actually took more than three months and raised serious questions about sacrificing autonomy and what services to offer. A "continuing challenge," Sheehan said, is the fourth moment—making the alliance work. "One has to be comfortable with the tension between competing with other not-for-profit organizations and collaborating with them," he noted.

Minnesota Experience

The Access Alliance between the Good Samaritan Society and Health Dimensions, an affiliate of the Benedictine Health System, is currently limited to Minnesota, though the organizations have facilities in other states. Although the alliance's original goal was "defensive," according to Dale Thompson, president, Health Dimensions, Inc., Cambridge, MN, it quickly began to focus on more positive objectives: creating models for managing care across the continuum and using resources to provide care most effectively. Originally a 50-50 joint venture, the

alliance is now a limited liability company.

Thompson said the alliance is "about a better way to provide services, rather than filling beds." In this role, the alliance has identified capabilities it must have: an extensive management information system; the ability to control physician behavior by working with primary care physicians and including physicians in top management; the capacity to market the health plan; and the ability to subcontract with hospitals and other providers.

The alliance is currently developing clinical assessment software, exploring a relationship with a hospital system and managed care plan to provide subacute care, and responding to the state's request for new ideas in providing Medicaid managed care.

Advising the audience to prepare for managed care (48 percent of persons eligible for Medicaid are enrolled in some type of managed care plan), Thompson said: "There's a lot to think about in applying managed care to chronic care. You need to take responsibility for how long-term care is reshaped."

> You need to take responsibility for how long-term care is reshaped.
>
> -Dale Thompson

"Sacredness of the Individual" Seen as Spiritual Key

Respect for individuality is vital in both healthcare leadership and care of the aging.

Individuality—"the divine presence in the human face"—is one of God's most amazing gifts, said John O'Donohue. "And in an increasingly homogenized world, individuality is very subversive."

O'Donohue, an Irish poet and philosopher who proved to be one of the assembly's most popular speakers, led sessions on spirituality as it applies to leadership and to aging. Individuality was a key concept in both sessions.

Spirituality and Leadership

Leadership should in fact "be grounded in the sacredness of individuality," said O'Donohue. He praised Catholic healthcare for preserving a sense of the mystery of the individual, in contrast to contemporary secular Western culture, "which talks on and on about an abstract self, in language that has grown banal, clichéd, and brittle."

O'Donohue said genuine leaders exhibit six characteristics:

- They have integrity. "In being true to themselves, leaders automatically bring change to their organizations."
- They help co-workers become aware of unsuspected talents in themselves. "Leadership is ministry in service to possibility."
- They are compassionate, "as was Jesus with the wounded and with outsiders."
- They are spontaneous. "Real leaders are quick to respond effectively to need."
- They understand human longing. "The consumerism that marks our time is a perversion of longing that has forgotten its source in mystery."
- They learn from failure. "In fact, leaders often see failure as a source of inspiration. Jesus knew that failure sometimes carries a hidden light."

Spirituality and Aging

Contemporary Western culture, which sees people as interchangeable as machine parts, has forgotten the great value to be found in an individual's experience, said O'Donohue. Aging people, who are especially rich in experience, often find themselves psychologically "evicted" in our society, he said.

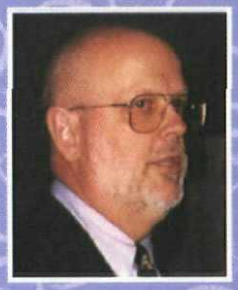
O'Donohue, a native of County Clare in western Ireland, likened older people to the poor farmers whom British landlords often evicted from the land in the centuries before the Irish gained their independence. "A society based on externalities such as youthful beauty always shoulders old people aside," he said.

"A sense of emptiness and loneliness are almost unavoidable aspects of aging in modern society," O'Donohue continued. "Old people wind up feeling like ghosts while they are still alive."

This is unfortunate both for the elderly and for society, he argued. "We desperately need old folks' wisdom because it would, if only we had access to it, bring balance to our frenetic lives." The great thing about aging is that it can give a person time to integrate his or her experience, O'Donohue continued. "Old age allows you to meditate on experience and, in doing so, forgive yourself for things you've done or neglected to do. What society wouldn't benefit from more of that?"

John O'Donohue

Attending to the Spirit



Richard W. Smith

Lead from Within So Others May Flourish

Servant leadership is lived out at three levels: individual, relational, and institutional.

Leaders are called to connect people together and then help them grow and develop, said Richard W. Smith, explaining the concept of servant leadership. "Leadership is a special case of service. And, as leaders, what we develop in ourselves can affect the world in a positive, caring manner."

Smith, senior educator at the Greenleaf Center for Servant-Leadership, Indianapolis, explained that servant leadership is about deep identity at three levels: personal, relational, and institutional. It asks the questions: Who am I? Who are we and why do we choose to have the relationship we do? Why is this institution choosing to be this type of institution? Not to be confused with management, which is a way of doing, leadership is a way of being, more concerned with relationships and connections than role definition.

When one is a servant leader, one is a servant first: called to serve. And as servant leaders evolve, they co-create community, shaping the environment for themselves and others. Servant leaders are listeners, Smith explained. "They learn to listen with what I call 'undefended receptivity.' They're not listening defensively or thinking about what they will say next. They listen to voices that are usually silent or that speak words we may not want to hear."

> Servant leaders use power ethically and persuade rather than manipulate or coerce. -Richard W. Smith

As well as listening, effective leaders raise questions. "Traditional leaders had all the answers, or thought they did. That's impossible to do anymore," Smith said. "So the important thing becomes to frame the questions in ways that clarify and probe the issues." Smith

Conference, New Programs Transform Care of the Dying

As a result of an "open architecture" conference sponsored by Supportive Care of the Dying: A Coalition for Compassionate Care (SCD:CCC), several Catholic healthcare organizations have recently made significant changes in how they care for dying persons and their families. The conference was designed to elicit creative ideas from participants (80 clinical, administrative, hospice, and spiritual care personnel from the 12 healthcare systems that, along with CHA, comprise the coalition), explained conference organizers Bobbie Ingram and Marsha Ladenburger. Since the meeting last November, participants have changed care in their facilities by creating needs assessment teams, pain clinics, and visions and goals for various new programs, said Ingram, vice president of care integration, Catholic Health Initiatives, Denver.

Open Architecture Process

"*Open architecture is a process that invites participants with similar interests to come up with ideas they* can take back to their facilities," said Ladenburger, senior vice president for healthcare innovations and evaluation, Daughters of Charity National Health System, St. Louis. She and Ingram took a risk in choosing the open architecture format, she said, because such meetings have no preplanned agenda or presentations. Rather, participants are asked to identify concerns about which they are "passionate" and then form themselves into work groups, each of which focuses on a particular concern. At the November meeting, the groups addressed 23 topics, Ladenburger said, and they developed goals and implementation plans for innovations in their organizations. Music enhanced the conference's open atmosphere, said Ingram, vice president, care integration, Catholic Health Initiatives, Denver.

Ladenburger urged assembly-goers to educate their staffs, using SCD:CCC's research. Through community focus groups, an SCD:CCC study—unveiled at CHA's 1997 assembly—identified the needs of dying persons and caregivers. A coalition video, available from CHA, as well as information on CHA's website

suggested that session participants take 30 minutes at a routine meeting and allow people only to ask questions. "The depth of those questions will astound you," he said.

In addition to listening and asking questions, servant leaders use power ethically, persuade rather than manipulate or coerce, and accept the responsibility of accountability in all three spheres: personal, relational, and institutional.

"When I talk to leaders," said Smith, "I ask them two basic questions: Does the way you lead get you what you want? and, What do you want? If you know the answers to those two questions, you can decide for yourself whether your leadership is effective."

Study Links Spirituality and Healing

CHA and six Catholic healthcare systems sponsored a study involving 166 chronically ill people.

The initial findings from a study sponsored by CHA and six Catholic healthcare systems confirm that a person's spirituality has a positive effect on the healing process. Researchers interviewed 166 adults with one of five chronic conditions: cancer, coronary artery disease, HIV/AIDS, chronic obstructive pulmonary disease, and chronic mental illness. According to Sr. Diana Bader, OP, senior vice president, Mission and Ministry, Catholic Health Initiatives, Denver, the study was designed to:

A person's spirituality has a positive effect on the healing process.

-Sr. Diana Bader, OP

- Describe what chronically ill people mean when they perceive themselves as spiritual
- Examine ways in which an individual's spirituality affects health and well-being
- Determine which elements of spiritual care are factors in holistic health and healing

Follow-up focus groups will likely be convened to more closely explore a means to document the spiritual growth experience of chronically ill people.

Many interviewees said they found meaning in life either through relationships (affirming, helping, or loving others) or actions (trying to make a difference, experiencing nature, or prayer). Most believed they were

Sr. Diana Bader, OP

(www.chausa.org), can help organizations conduct their own focus groups, she said. Ladenburger also invited audience members to replicate the open architecture conference with their own multidisciplinary staff in order to find ways to improve the care of persons at the end of life.

Community-Based Programs

Two Catholic hospitals are completing the groundwork for community-based programs that provide supportive care to the dying and their families. The two programs—one, coordinated by St. Joseph Healthcare System, targeting Mexican immigrants in Albuquerque, and the other, organized by St. Mary's Medical Center, reaching families in Evansville, IN—are designed to integrate the cultural values and norms of their communities into a supportive-care model based on the work of SCD:CCC. Both hospitals have formed focus groups to gather information and analysis teams to tailor care to their regions and generate community involvement.

Since nearly 9,000 Albuquerque residents were born in Mexico, bridging the language barrier will be one of the challenges facing St. Joseph. Staff members provided transportation, baby-sitting, and $10 stipends to low-income participants of the focus groups. Because some participants feared losing their legal status, they were assured their comments were confidential. Providing supportive care is critical because many in the Mexican community have difficulty accessing the healthcare system, said Evelyn Baca, St. Joseph's vice president, Mission Services. "We're serving the truly marginalized."

The picture is radically different in Evansville, where St. Mary's is serving a strong German Catholic community whose members often keep their health issues private, said Mary Simpson, vice president, Clinical Services. The average household income is about $4,000 below the national average. Overcoming some initial community skepticism, St. Mary's now has an enthusiastic seven-member analysis team, which will become part of a broader community steering committee.

responsible for their illnesses because of poor health behaviors, stress, punishment for past actions, or working too hard. Many also had a strong hope—"not a naive optimism but an ability to stay on course," Sr. Bader said. They believed actions that help healing include being a strong person, having faith, having fun, taking medications and treatment, praying, and trusting health providers.

The study shows that pastoral care plays a significant role in the healing process, but even more could be accomplished by getting into the community, Sr. Bader said. "Spiritual care that is predominantly based in an institution really leaves out a major, major segment of opportunity for working with people who are in need." Those with HIV/AIDS, unlike the other groups, were dealing with social isolation. "They are struggling with anger and a sense of abuse and abandonment by the Church," Sr. Bader said.

The six systems involved in the study are Sisters of Providence Health System, Seattle; Catholic Healthcare West, San Francisco; St. Joseph Health System, Orange, CA; Carondelet Health System, St. Louis; Catholic Health Initiatives, Denver; and Daughters of Charity National Health System, St. Louis.

Everyday Spirituality Can Help Healthcare Professionals Sustain Their Passion

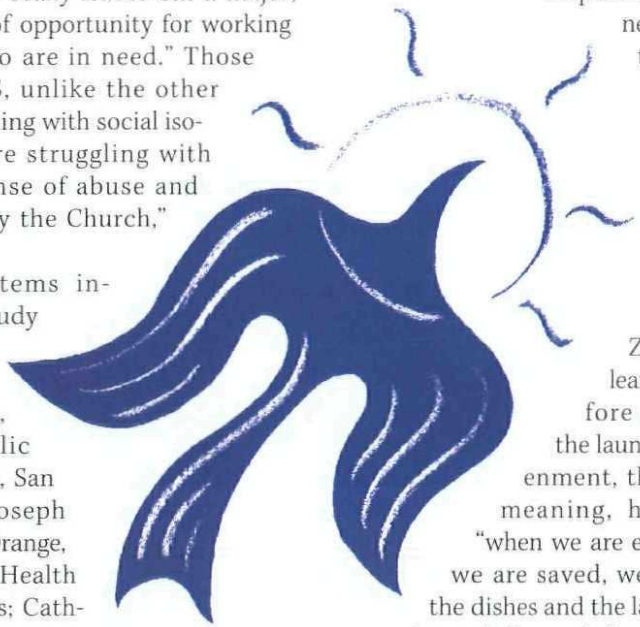
Living in the present, listening to stories, and relying on friends allow us to cope with crisis and change in the corporate environment.

In today's world of rapid change, diverse values, and constant crisis, how can healthcare professionals sustain themselves and regain the passion that brought them to healthcare in the first place?

Rev. Joseph Gillespie, OP, spoke of the importance of developing a spirituality that enables us to explore not just our inner world but also the marketplace, "so we can find out how to keep from losing our spiritual identity in an increasing secular environment."

Rev. Joseph Gillespie, OP

His first suggestion for developing such a spirituality is learning how to live in the present. Fr. Gillespie, who is professor of pastoral care and counseling, Aquinas Institute of Theology, St. Louis, said that, when he was a hospital chaplain many years ago, a patient questioned why he was so anxious to get away from her, why he kept looking at his watch. "I couldn't be there in that moment," he said, "and this was the ultimate insult to her and to me." After that experience he took off his watch and never put it back on. Although we need to be on time and be responsible, he said, we need to ensure that time is not our driver.



Another aspect of living in the present is the intention with which we act. Fr. Gillespie quoted a Zen aphorism he learned in India: "Before enlightenment, the laundry. After enlightenment, the laundry." The meaning, he said, is that "when we are enlightened, when we are saved, we continue to do the dishes and the laundry, but we do them differently"—with a sense of understanding that God is in the process.

He noted that even in the most stressful situations, it is important to "push aside thoughts that you can't be happy." One can learn to be happy, to find a oneness with God, he advised, "in the quietude of a new chapter of one's life."

Another method for finding spirituality in a corporate world, Fr. Gillespie advised, is to tell stories about our faith and, just as important, to listen to them. The integrating influence of Jesus, he explained, is in listening to stories about Gospel values and seeing how they draw us into continuity or incongruity with our surroundings—"to find balance between what's going on in here and what's going on out there."

Like Dorothy in *The Wizard of Oz*, he said, we are constantly trying to get back to our roots—"not to live in the past but to understand the catalytic dimensions of the past that pushed our founders and foundresses to do something that was

extraordinarily different."

Finally, Fr. Gillespie advised relying on friends or a community, such as a church. "The old definition of friendship is that it doubles our joy and divides our grief," he said. "You need to find someone with whom you can talk, someone who will stand with you as you begin to agonize with self-doubt. This is where spirituality can be rekindled in the crucible of change."

The Gifts of Faith

According to Rev. Joseph Gillespie, OP, faith offers three gifts that help nourish the spirit on a daily basis:

- Freedom from fear. Unrealistic fear may cloud our judgment and prevent us from finding the inner equilibrium necessary to face tough situations. "Even though there are trials and tribulations, if you believe, you need not be afraid."
- Enduring values. Faith draws us back into an examination of elusive values to answer the question, What are we trying to accomplish, not only as individuals but as members of corporations, communities, or boards?
- Trust in life. Most people are planners—they like to organize, to quantify, to know how everything's going to come out. With faith, we can allow the surprise of life to happen, allow spirituality "to inform us rather than conform us."

Advocacy/Public Policy

Finding Common Ground in a Pluralistic Society

Catholic providers seek ways to maintain Catholic identity in the face of opposition to their stands on reproduction and physician-assisted suicide.

The challenge of maintaining Catholic identity in a pluralistic environment, according to Rev. J. Bryan Hehir, ThD, professor at Harvard Divinity School, Cambridge, MA, is finding common ground for living in a society where there is ultimate disagreement on questions of central importance.

> Catholics must start a positive dialogue with those who disagree.
>
> -Rev. J. Bryan Hehir, ThD

"We have to identify which issues are essential to the welfare of a society and then find ways to talk about them," Fr. Hehir said. A fundamental disagreement between Catholic providers and their opponents is whether reproductive choices should be public or private issues, he said.

Finding allies is complicated by the fact that major political factions differ with the Catholic stance on critical issues. Liberals agree with Catholics on social issues such as social justice and poverty but disagree on reproductive issues, whereas the religious right disagrees with Catholics on social issues and agrees on reproductive issues.

In the face of these difficulties, Fr. Hehir explained, the resources the Catholic tradition brings to bear are its ideas—a moral vision that cuts across every social principle—institutions that do not just teach but "lay hands on life," and a community that is the largest religious group in the United States. With these resources, Catholics must work to defend legitimate space, start a positive dialogue with those who disagree, and search for common ground to try to shape the whole society.

Reproductive Services

The challenges are particularly acute in New York, where Catholic healthcare providers have received a wake-up call, said Mary Healey-Sedutto, PhD, director of Health and Hospitals, Archdiocese of New York. Five bills currently in the state legislature may

Mary Healey-Sedutto, PhD

Bridget Carney, PhD

present them with a Hobson's choice: compromising their ethical beliefs or withdrawing from healthcare ministry and abandoning the poor.

"I am in shock at the rapidity with which these issues have developed," said Sedutto. "In the past months, five bills have moved through the assembly into the senate that will fundamentally challenge our ability to remain in healthcare."

The bills would require managed care organizations to provide all the reproductive services proscribed by the Church; require all member corporations to be licensed providers, so Catholic sponsors would be subject to the same regulations governing facilities; prohibit reductions of reproductive and family planning services unless providers attest to the availability of these services elsewhere; require every provider to offer abortion or family planning services; and require 90-day prior notice of intentions to apply for a merger, giving opponents time to mobilize the community.

"Our opponents have a frightening and insidious strategy," said Healey-Sedutto. She characterized them as well organized and methodical; well funded; skilled at innuendo and misinformation; out of sync with the wishes of the community; armed with an effective public relations strategy; and sophisticated in their focus on a legislative remedy.

"They have learned how to use our own strengths against us," she said. "They speak of their mission, of their core values, their ministry. They attend our meetings and participate in the discussion. They praise us with *great flourish," but then move on to* the one "deficit": that "we are preventing society from having access to what they see as societal rights."

The good news, she said, is that Catholic providers are coming together as never before. New York's eight dioceses and well-organized state Catholic conference have developed a full-force legislative response, an integrated and consistent public relations campaign, and a set of guiding principles to ensure continuity of message in different communities.

Physician-Assisted Suicide

In Oregon, the search for common ground failed last year, when Catholic providers lost the battle against legalized physician-assisted suicide. "The law puts us into conflict," explained Bridget Carney, PhD, corporate director of ethics at PeaceHealth, Bellevue, WA, "because legally we can't censure physicians for providing assisted suicide. At the same time, we have the right not to participate."

While seeking to clarify the legislation's conscience clause, PeaceHealth has taken several steps to uphold its ethical convictions:

- Each system facility instructs both employed and nonemployed physicians that its assisted-suicide policy is "not on our time, and not in our facilities," Carney said.
- Persons in the hospital who have attempted physician-assisted suicide are cared for as *any other type of suicide.*
- The hospice policy, which is still being finalized, is to admit anyone, whether or not they have expressed wishes for assisted suicide. "We won't abandon them," said Carney, but the hospice makes it clear that staff will not be present during a suicide effort. Then staff try to find out why the person wants to commit suicide and explores the options available.
- Finally, PeaceHealth (a member of the Supportive Care of the Dying coalition) promotes its values through improving pain management, educating physicians and staff, care planning, and collaborating with other Catholic providers to learn how they approach certain issues.

Compliance Program Protects from Fraud, Abuse

An effective program can ease "tomorrow's headaches."

Even if Catholic healthcare leaders are confident they have complied with federal regulations on Medicare reimbursements, they must still develop an effective corporate compliance program to protect them from possible fraud and abuse investiga-

tions by the government.

"If you understand what the government is looking for and you act seriously with corporate compliance, hopefully you will be able to avoid some of the sanctions imposed against others," said Sanford Teplitzky, chairperson of the health law department of Ober, Kale, Grimes & Shriver, Baltimore.

Daniel Hale, senior vice president and general counsel, Holy Cross Health System, South Bend, IN, urged healthcare leaders to teach their management teams, boards, and medical staff how to prevent the mistakes that could trigger an investigation. Holy Cross, which went through an investigation, found the financial and human costs were high, including attorney and public relations fees as well as counseling expenses.

> Teach management teams how to prevent mistakes.
>
> -Daniel Hale

By taking steps to put a corporate compliance program in place, healthcare facilities can reduce "tomorrow's headaches," said Michael Shaw, associate counsel, Office of Inspector General, Department of Health and Human Services. Some of the essential elements of a compliance program include:

- Establishing compliance standards and procedures
- Designing a code of ethical conduct
- Assigning oversight responsibility to individuals high in the corporate structure
- Conducting effective training and educational programs
- Monitoring and auditing to ensure compliance with standards
- Developing effective lines of communication
- Enforcing standards through discipline
- Responding appropriately to detected offenses

While the government has been easing up on its zero-tolerance policy, which often punishes people who unknowingly violate regulations to the same degree as it punishes those who deliberately abuse the system, Teplitzky said healthcare leaders still have to protect themselves. "I will suggest to you there are more people looking for fraud and abuse than there are people committing fraud and abuse."

Because fraud and abuse such as double billing and filing false claims do occur, the government's intervention is necessary, Shaw said. Through corporate compliance programs, the industry has the opportunity to clean itself up, according to Teplitzky.

Sanford Teplitzky

Michael Shaw

Sr. Patricia Siemen, OP

John S. Lore, PhD

Group Discusses the Future of Sponsorship

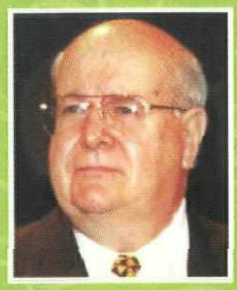
Issues of sponsorship sparked participants' thoughts and comments at a dinner sponsored by Health Progress. Guest speakers Sr. Patricia Siemen, OP, health ministry coordinator, Dominican Sisters Congregation of the Most Holy Rosary, Adrian, MI, and John S. Lore, PhD, president and CEO, Sisters of St. Joseph Health System, Ann Arbor, MI, shared their views on the future of sponsorship from the religious and lay perspectives. Sr. Siemen spoke of her conviction that "in the future we—religious and lay—will be working together in sponsorship." She called for the development of leadership, both lay and religious, for the future. "We need to be in partnership with the laity and be formed and shaped by them as much as the other way around," she said.

Dr. Lore credited the Sisters of St. Joseph for their tremendous confidence in his ability to carry out their mission. Looking ahead, he predicted that new lay charisms will shape the future.

An open discussion brought forth comments on the importance of choosing leaders who exhibit an understanding of ministry and the need for a supportive environment in which sponsorship and the work of the ministry can flourish. Sr. Jean deBlois, CSJ, RN, PhD, vice president, Mission Services, CHA, St. Louis, who facilitated the discussion, added, "It takes a community to sponsor a corporate work of the Church in the world."

Participants agreed that the conception of religious and laity as "us" and "them" is fading. "It is the ministry of all of us," Sr. deBlois said.

Medicine as Mission



Robert McAfee, MD

Physicians and Catholic healthcare can share ethical values and commitments.

Physicians and Catholic healthcare share a centuries-old tradition of concern and respect for human life and dignity, said Robert McAfee, a surgeon and former president of the American Medical Association (AMA). McAfee spoke of the similarities between physicians' professional code of ethics and the *Ethical and Religious Directives for Catholic Health Care Services*, and pointed out that what lies behind physicians' ethics marches with the goals of Catholic healthcare.

The AMA was founded in 1847 for three reasons, explained McAfee: to establish a professional code of ethics for medical treatment appropriate for this country; to guarantee the best-quality education possible for students, residents, and physicians; and to protect the doctor-patient relationship from outside interference. "That foundation is equally as necessary for those three reasons today as it was in 1847," declared McAfee.

The AMA recently published the 150th edition of its code of medical ethics, which, like the directives, has its roots in the Judeo-Christian tradition. "When you read the two, you are impressed that they are essentially the same," said McAfee. "There are very few statements in the AMA code that are not endorsed, duplicated, or complemented by the directives."

End-of-life care, for example, will be a major initiative of the AMA over the coming years through a series of physician "train the trainer" courses in conjunction with the Robert Wood Johnson Foundation. The courses, McAfee said, will emphasize "end-of-life care, humanism, dignity, and the need to eliminate technological care when it becomes obvious what the outcome will be." He added that there are plans to change the curriculum of medical schools so that this will be an early part of the education of every physician in America.

The physicians' code of ethics covers a variety of other issues that converge with the Catholic viewpoint, according to McAfee. Physician-assisted suicide is, for example, "abhorrent to our association." The code also covers such issues as genetic manipulation, informed consent, conflict of interest, patient advocacy, and family violence.

"The code demands of each of us two things—character and civility," McAfee said. With the pressure of modern healthcare finances and delivery systems, he warned, everyone in healthcare must avoid the temptation to use ethical shortcuts. "Ethical shortcuts can easily become habits, which lead to loss of respect from others and of self. It takes self-respect, self-assurance, and self-confidence to be compassionate with others. Compassion is a terribly important part of one's strength, and you at CHA demonstrate that every day."

> Compassion is a terribly important part of one's strength.

In medical education, McAfee suggested that it may be time to reevaluate the standards that determine which applicants to medical school will make the first cut. Instead of relying exclusively on MCAT scores, "Is it not time for use to look at that special blend of humanism and intelligence? Someone who has shown service, character, and civility?" McAfee asked.

McAfee also discussed the need to alter the medical school curriculum, saying that we need to infuse our curriculum with the issues of public health.

McAfee had strong words for managed care, calling it a blip in the history of our country. "History will judge the success of managed care on how well it either protects or destroys the doctor-patient relationship," he said.

Calling mission a sense of duty to a population of patients, McAfee said one can fulfill that duty by being a "link in the chain, a light that will not go out." This must be the commitment of our professions, he said, working together in solid partnership to fulfill the mission of medicine.

Historian Says Leadership Means Confidence, Compassion

Continue to defend the vulnerable, a Pulitzer Prize winner urges the Catholic health ministry.

Doris Kearns Goodwin

Self-confidence, a good sense of timing, compassion for the vulnerable, and an ability to make people feel connected—these are among the qualities required for great leadership, historian Doris Kearns Goodwin said in the assembly's annual Flanagan Lecture.

Goodwin, a Pulitzer Prize-winning author of books about Lyndon Johnson, Franklin and Eleanor Roosevelt, and the Kennedy family, drew on both scholarly studies and personal experience in discussing leadership as a transforming agent.

She was especially moving on the subject of Johnson, a president she served first as a young White House intern and later assisted in the writing of his memoirs. A Harvard student active in the antiwar movement in the late 1960s, Goodwin admitted that when she was named to the internship she had a strong bias against Johnson. "But I developed a great empathy and respect for him," she said.

Johnson had wonderful leadership skills, but he was much better at using them on domestic matters than on foreign policy issues, Goodwin said. "Winning passage of the civil rights bills of the mid-sixties was his great triumph," she argued. Because he was a Southerner and a man who needed to be loved, his fierce stand against racial discrimination came as a surprise to many people, she noted. "But like other real leaders, he had an urge to do the right thing that transcended his great wish to be popular."

Goodwin said Johnson took care to include even opponents in discussion of the civil rights bills. "If you want folks in on the landing, you've got to make sure they're in on the takeoff," she recalls him frequently saying. But Johnson was unable to exercise this talent for inclusion in his waging of the Vietnam War, Goodwin noted. Indeed, she said, it was his secretiveness about the war that finally helped make it—and him—so unpopular with the public. "That was his tragedy," Goodwin said.

Franklin D. Roosevelt's great leadership qualities included "his absolute confidence in himself, his country, and its democratic system of government," Goodwin said. It was this gift that enabled FDR to project to his fellow Americans "a great sense of hope, strength, and serenity" even in the darkest days of the Great Depression. Roosevelt also had a terrific ability to make people feel connected to one another and engaged in a common project, Goodwin noted.

In the early 1940s, she said, FDR used his skills to persuade Americans to get involved in World War II even though many had shortly before been isolationists. Once the United States had entered the war, he worked hard at making sure everyone understood its progress. Goodman described a radio speech FDR gave in early 1942, when America seemed to be losing. The president explained various military campaigns in such detail that he had his listeners across the nation following his talk with their maps. "Don't you sometimes wish our leaders today could get us feeling that involved?" Goodwin asked the audience.

Eleanor Roosevelt also had wonderful leadership gifts, especially compassion for the poor and powerless, Goodwin said. The historian particularly noted Eleanor Roosevelt's many wartime travels around the country, after which she would return to the White House and entreat her wheelchair-bound husband to do more for coal miners, for example, or women working in defense factories, or African Americans. When, late in the war, FDR compelled segregationist transit workers in Philadelphia to admit a black bus driver to their ranks, Roosevelt did so at his wife's urging. "Franklin and Eleanor were not only great leaders but a great leadership team," Goodwin said.

She urged leaders of the Catholic health ministry to continue to inculcate such leadership qualities in the men and women who will be their successors. "I especially admire Catholic healthcare's traditional compassion for the weak and vulnerable of our society," Goodwin said. "I certainly hope that is a tradition you will maintain."

Balancing Managed Care Quality and Costs

Employers, providers, and consumers must share responsibility for improving health plans' performance.

Charles J. Ogletree Jr., JD

Anne R. Nedrow, MD

Margaret O'Kane

Employers want to ratchet down their healthcare costs, providers want to improve their operating margins, and consumers want assurances of access and quality. Is it possible for all of those needs to be served in the current healthcare delivery system? What should the government's role be?

Those were among the issues addressed by a panel of experts in a Socratic-type dialogue moderated by Harvard Law School professor Charles J. Ogletree Jr., JD.

Panelists agreed that managed care has been a good thing for controlling costs, but many voiced concern that consumers were not adequately protected by the current system, nor do they understand their rights and responsibilities. Consumers need information so that they can make wise decisions about their care, and they need procedural protection, said Ron Pollack, executive director, Families USA, Washington, DC. Pollack supports the proposed patients' bill of rights for managed care currently being considered in Congress. Laypersons need to understand and accept responsibility for prudent use of the healthcare system, he said, but they also need guarantees of a minimum threshold of care, with an appeals process when they have been unfairly treated.

> Consumers need information to make wise decisions, and they need procedural protection. -Ron Pollack

"To a certain extent, this horse is already out of the barn," countered Walter B. Maher, director, public policy, Chrysler Corporation, Washington, DC. Existing legislation protects patients from being turned away from the emergency room, and Congress's patient bill of rights legislation should provide needed protections, he said.

"My company spends $1 billion a year in healthcare," Maher pointed out. In a patient mix of that size some claims will be denied. "We do make use of external reviews for highly technical or experimental procedures," he said, but it is impractical to review each one. The first line of consumer protection, he believes, would be for insurers to streamline their claims review process.

Ogletree's question about patients' perspectives on managed care drew quick reactions from two CHA members on the panel.

Confusion reigns among consumers, according to Anne R. Nedrow, MD, an internist at the Portland Clinic and medical director of women and children's programs, Providence Health Systems, Portland, OR. For example, many do not understand insurers' second-opinion requirement. They do not know the procedure for complying or that they are responsible for it, she said.

The confusion is also manifested in consumer decision making. "Seniors have the greatest fears and say they hate managed care," and yet that's the option they tend to select when given a choice, she said. Nedrow said HMOs are awash in negative publicity and should be doing more to communicate their positive aspects, such as trying to keep people healthy. The number of women getting mammograms is up, and the incidence of first-stage breast cancer is down, due in part to the preventive emphasis of managed care, she said.

Greg Van Pelt, chief executive of Providence Health Plans, Portland, OR, said his organization is looking at risk models that provide physician incentives for improving the quality of care rather than just trying to decrease utilization. The effort involves communicating more with patients about their role in their own health, as well as improving coordination across the continuum of care. "When all the pieces are in sync," he said, "we're building a better system of care."

The short-stay maternity policy adopted by many insurers is an example of a situa-

tion in which consumers were not confused, insisted Margaret O'Kane, executive director, National Commission for Quality Assessment, Washington, DC. Their unhappiness provoked government interest in quality standards. "HMOs need to work more on their relationships with patients," she said. They need to put something into their plans that gives beneficiaries confidence that their interests are being taken into account.

Van Pelt expressed concern about the role of government in trying to legislate good patient care. Managed care has had a positive impact on care of those who traditionally had the least access, he said. "That's what fuels our passion. Providing quality care isn't about the government imposing standards. It's about providers getting together and doing the right thing."

Giving consumers a greater choice of plans is the best way to improve quality because it will force plans to compete on quality, according to Walter A. Zelman, PhD, health policy instructor at Harvard's School of Public Health. The patients' bill of rights will do some good, but it's not going to make managed care improve performance, he asserted.

At least two panelists said the discussion on quality standards deflects attention from a more serious issue. The number-one public policy priority should be getting access to care for the millions of uninsured Americans, Pollack said. "If healthcare is treated like a market product, it's already got the wrong moral framework," agreed Rev. J. Bryan Hehir, ThD.

In the absence of a movement for universal coverage at the federal level, Catholic organizations and other supporters must do what they can to advance healthcare as a moral right. "We've got to keep talking about how narrow this current debate is," Fr. Hehir asserted. "There's not a major politician in this country willing to reopen the healthcare debate, so it has to go on in other circles and be pushed into the political process."

Innovators in Healing '98

Two Catholic healthcare organizations have won 1998 Catholic Health Association Achievement Citations for programs that improve their communities' health status.

Latino Health Promoter Program

Providence Health System/Los Angeles Service Area
Los Angeles

The Latino Health Promoter Program (LHP; photo, top right) was begun in 1993 after a community assessment revealed that language barriers kept many Hispanic residents from getting healthcare.

LHP recruited Spanish-speaking volunteers, many of them parishioners of area churches, to help conduct screenings for problems such as diabetes, hypertension, breast and cervical cancer, substance abuse, and domestic violence. To date, the program has served more than 6,000 members. Today LHP volunteers also help conduct health education through home visits and seminars in neighborhood churches.

Kids Programs

St. Bernards Regional Medical Center
Jonesboro, AR

Since 1993, Kids Programs (photo, right) have, by targeting problems with children's health, worked to improve overall community health in northeast Arkansas. The problems addressed include inadequate prenatal care, low immunization rates, insufficient preventive health screenings, poor hygiene, and a general lack of health awareness. Kids Programs' staff has provided direct care for nearly 4,000 of the region's children. In addition, Kids Programs have joined statewide campaigns to provide health education to thousands of other Arkansans.

Rev. Michael D. Place, STD

President's Address

The Faces of a Community in Ministry: Passionate, Determined, Responsible

Rev. Michael D. Place, STD, was commissioned as CHA president and chief executive officer on June 7, 1998. In his first address to the members, he proposed ways CHA and members can address critical ministry challenges.

It is still unbelievable to me that I am standing here as president of CHA. The life movements, dare I say God's grace, that have taken me from parish, to classroom, to office, to this moment are truly amazing. As surprised as I am, I am even more grateful for the opportunity to commit this portion of my life to what has been correctly called an essential ministry of the Church: the ministry of healing in the name of Jesus. At the same time, I am humbled by the responsibility that has been given me and acutely aware of how much I need your prayerful support.

When I was asked if I would accept an invitation to be interviewed for this position, my first reaction was, "Are you crazy?" I was aware of the baggage I carry as priest and diocesan bureaucrat. Having been assured, however, that these are not fatal flaws, I accepted the invitation. In discerning my response should I be offered the position, I began thinking about the ministry, about CHA, and about what I would do if the impossible happened and I was asked to serve as CHA's president. I stand before you now because the impossible *did* happen.

Shortly after accepting the position, I realized that one of the first things that CHA, and now I as part of CHA, must do is to enter into conversations with all elements of the ministry to understand better who we are as the Catholic Health Association. For CHA is not an organization distinct from its members. Rather, it is the sum of its many parts, existing only in and through its members. Thus CHA's true identity is "us." That being the case, I further realized that a hallmark of CHA, from this moment forward, must be a style of participatory dialogue in which all the voices of the ministry can be heard. I propose that this dialogue be thought of as "concentric circles of conversation" that actively engage the many persons who carry on the work of this ministry. And the focus of those conversations should not be CHA, but rather the ministry that CHA and all its members exist to serve.

Most of my remarks this afternoon, then, will focus on the ministry of which we are all a part. First, I will share with you some of what I have seen and heard about the Catholic health ministry during the past few months. Building on those experiences, I will outline what I believe are some of the critical issues we face as a ministry. I will conclude with three proposed ways to address these issues as we move together into the future. At the business meeting tomorrow I will discuss what I have heard from you about CHA and how we are responding to your concerns.

What I Have Experienced

Over the past four months, I have had the privilege of visiting many people who are engaged in Catholic health ministry in various areas of the continental United States. Though I feel as if I have seen a great deal, in

fact I have seen only a small sampling of the richness and diversity that is Catholic healthcare. For this reason, in the months and years ahead I will continue my travels and visits.

In many ways my recollections are best captured in faces:

- The face of the Mexican woman, an illegal immigrant, as she looked with love at her baby born recently at St. Joseph's Hospital in Phoenix
- The wrinkled face of a premature African-American infant with neurological problems being cared for so gently by a male nurse in the neonatal intensive care unit at Santa Rosa Children's Hospital in San Antonio
- The quiet dignity of a person with Alzheimer's disease as he stared vacantly out at the garden at Providence Hospital's Carroll Manor Nursing & Rehab Center in Washington, DC
- The worried face of a wife standing at her husband's bedside in the intensive care unit at Mercy Health Center in Oklahoma City
- The proud and energetic face of the director of the Spiritual Care Center at St. Joseph's in South Bend, IN, as he described community outreach programs
- The weary but determined face of the president of Northwest Covenant Medical Center in New Jersey as she described the complex challenges her organization faces
- The quietly elegant face of a Presbyterian woman who is responsible for mission at an ecumenical hospital, St. Luke's, that is part of Unity Health System in St. Louis
- The knowing face of a woman religious as she reflects on the challenges of sponsorship and mission for a system that is part of Catholic Healthcare Partners in Cincinnati
- The determined face of a Cardinal in New York who wants the hallmark of our ministry to be our response to poor and vulnerable persons
- The perplexed face of a Catholic Charities executive in Chicago trying to find ways to integrate long-term care more effectively into the full continuum of care

Faces. Faces that, when viewed through the eyes of faith, reveal to us the face of God and remind us what we are all about: being instruments of God's healing love. As a ministry of the Church, Catholic healthcare exercises that instrumentality in a special way through individual institutions and systems. As Bryan Hehir frequently reminds us, the work of this ministry "is done by institutions that lay hands on life at the critical points where life can be injured or fostered, where people are born and die, where they learn and teach, where they are cured and healed, and where they are assisted when in trouble."

In other words, the work of this ministry is sacramental, for it makes Christ present in our midst so that God's reign may flourish and grow toward its full realization.

Let us be thankful, let us be confident, as we consider and build our future together.

It is the sacramentality of who and what we are that I have experienced in my visits, in gatherings such as the Consolidated Catholic Healthcare Forum, and in our recent regional meetings with system sponsors and CEOs. It is the sacramentality of who we are that I experienced as various constituencies became one at the *New Covenant* Steering Committee and the National Coalition for Catholic Health Care Ministry. In all those encounters, I have experienced, in quite tangible ways, at least four realities: the *passion* and commitment of persons involved in this ministry; the *determination* that ours should be viewed as a time of opportunity and not of complacency; a deep sense of *responsibility* to ensure that we capitalize on these possibilities and challenges; and, finally, the rather Catholic *desire to come together* to actualize, to experience, and then to celebrate the "more" that we are when we are together.

My friends, look around this room. Look at the person to your right and to your left, in front of and behind you. Look at this gathering. Look at these faces of the Catholic health ministry. See the Table of Thanksgiving and the Book of God's Word. Let us be thankful, let us be confident, as we consider and build our future together.

Four Challenges

In this context of confidence, I now would like to consider four of the major challenges we face together as a faith-based ministry. While this list certainly is not definitive, I believe the following demand our immediate attention:

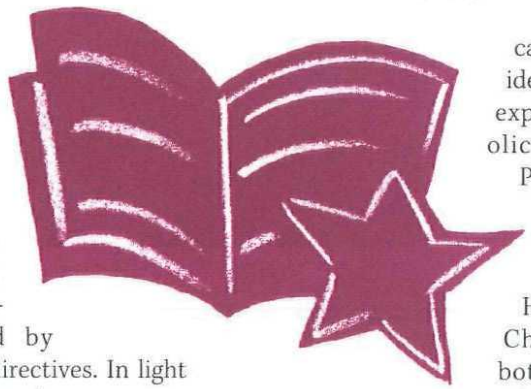
- The need to strengthen ministry identity

- The need to foster ministry leadership
- The need to develop appropriate ministry structures
- The need to deepen understanding of and commitment to healthcare as a social or public good

While each challenge may seem daunting, each offers us an incredible opportunity to reinforce and build on what already exists.

Strengthen Ministry Identity

During recent years the Catholic health ministry has been very intentional about working to sustain and enhance its identity. Our experience is not unlike that of our colleagues in Catholic education and social services. We, too, are experiencing greater need to attend to questions of identity as we become more successful at developing large and complex delivery systems that interface with and must respond to demands made by government, big business, and the marketplace. As we discuss how best to respond, we are assisted, of course, by the *Ethical and Religious Directives for Catholic Health Care Services.* We know, however, that identity is informed and shaped by much more than the directives. In light of this, I offer two observations.



First, we do not seek to strengthen our ministry identity in order to separate ourselves from others. The provision of high-quality healthcare is a human venture that we share with many persons of good will who are motivated by the same core values that motivate us. Rather, we seek to strengthen our identity to ensure that the *raison d'être* at the very heart of who we are as a ministry is expressed unequivocally in everything we do. The consistency between the claims we make and our actions in light of those claims will be what *distinguishes* us in healthcare, as in all other endeavors.

My dear friend, Card. Joseph Bernardin, who was so influential in my life, sought to assist us in clarifying what distinguishes us as Catholic. In his pastoral letter, *A Sign of Hope,* Card. Bernardin wrote: "Our vocation in Christian healthcare is not so much to heal better or more efficiently than anyone else; it is to bring comfort to people by giving them an experience that will strengthen their confidence in life." The difficulty, of course, is that measuring an outcome like hope (or, in the language of the trade, "benchmarking hope") is difficult if not impossible.

If we are unable to measure hope, how are we to know whether our efforts at strengthening our identity are successful? This question leads me to my second observation. Although there are external marks that should and do convey who we are, delineating those marks or characteristics should not be our primary concern. To do so would be to delude ourselves into believing that identity is produced by activities. On the contrary, it is identity that is the source and purpose for activities. In other words we cannot guarantee we have strengthened our identity merely by proclaiming that we provide high-quality healthcare, or our work environments are places of justice, or we offer compassionate care to dying persons and their families.

Does this mean we can never know if self-identity is an authentic expression of the Catholic health ministry? Perhaps a quotation from the theologian Raimon Panikkar can help us. He has noted, "A Christian is one who both confesses oneself to be such and as such is accepted by other people." From this perspective, there are two essentially related components of any self-analysis of our Catholic identity. First, we must ask ourselves, What do we confess when we say we are Catholic health ministry and what does this confession require of us? Second, we must ask, What is it that others say about us? Patients, families, physicians, nurses, office workers, and many others will affirm who we really are in the stories they tell about us, just as they have throughout the history of this healing ministry. As we seek to strengthen our identity, let us have the courage and humility to truly hear the stories of those we serve.

Our goal is that the thousands upon thousands of stories they tell sound like the stories people would have told about Jesus, like the stories people would have shared in recounting the life and works of so many caring and visionary people in Catholic healthcare: Mother Catherine McAuley, who began visiting homes

of the sick and impoverished in Ireland and later founded the Sisters of Mercy; Henriette de Lille, who established a congregation of African-American sisters—the Sisters of the Holy Family in New Orleans—to take care of slaves who had been cast off by their owners; St. John of God, who built hostels for the sick poor in Spain and founded the Hospitaller Brothers of St. John of God; Mother St. Augustin Tranchepain, a French Ursuline, who arrived in New Orleans in 1727 and by 1728 had built a hospital, established a school, and founded a home for orphans; Bonaventure Thelen, an Alexian Brother who established the congregation in the United States and opened Alexian Brothers Hospital in Chicago in 1866; Mother Mary Odilia Berger, who emigrated from Germany to serve the sick poor crowded in unsanitary tenements in 19th century St. Louis; and many others we could name.

If the stories about us are as powerful as these, then we can be confident we have become effective signs of hope, bearers of God's love.

Foster Ministry Leadership

The second challenge is to call forth and nurture leadership for the future. This ministry has been and is blessed with many wise and gifted leaders—women and men, religious and laity. Many of them are in this room. Many present ministry leaders grew up within a strong Catholic culture that provided a kind of formation for them, a formation that rooted them firmly within the Catholic tradition, a formation that helped shape the way they think and act. However, that strong culture no longer exists as it did in the past. Thus we are left with the question of how to develop future leaders who are equally rooted in the tradition and imbued with and motivated by the values of the Gospel. As in the past, much of this work will be done by the Spirit. But we share responsibility for the task. We must ensure that the soul of this ministry is passed on in such a way that tomorrow's leaders, Catholic or not, are up to the challenges of the next millennium.

We all know that it is not enough to hand people the Code of Canon Law or a set of directives and expect them to be able to steward the ministry wisely. Nor is it sufficient to rely exclusively on programmatic approaches to identify and develop leaders for the future. We must seek ways to pass on to future leaders the Catholic imagination with all its richness, depth, and complexity. Whether they sponsor, govern, manage, practice the healing arts, or collaborate in such roles as aides and technicians, all must share a common vision that will make it possible for them to steward well this ministry that has been entrusted to us.

As a parish priest, I have experienced first-hand the transforming power of our stories and the processes by which they are shared. To date, we in Catholic healthcare have accomplished a great deal in this area. However, we have not developed a consistent approach nor the collective, expressed commitment necessary to ensure success. This is something we must do *now*.

Develop Appropriate Ministry Structures

A third challenge is to strengthen the structures that support this ministry. Immense creativity has resulted already in new forms of sponsorship, new corporate structures, and new alliances within the ministry. Many of these efforts, however, have been directed exclusively at horizontal integration within what we traditionally understand as Catholic healthcare.

Although these efforts will continue, we must also pursue more aggressively vertical integration. This will require that we think of healthcare more broadly and more appropriately than we have in the past. Spurred on by the *New Covenant* process, Catholic healthcare organizations are developing partnerships with Catholic Charities, with groups such as Mercy Housing, with Catholic schools and parishes. The thorny question, of course, quickly emerges: Who will be in charge? The answer to that question must be arrived at very carefully and always with an eye toward the goal we are seeking. Let those religious institutes which have let go of what they have held dear for so long in order to cosponsor something new be a witness to us all. If we are to create the kind of health system that truly will serve the integral good and well-being of persons and communities, we must be bold and willing to take risks, even risks unto death.

As we move ahead, we also must consider new ways to partner with and support physicians. The changes occurring within the American healthcare system pose significant impediments to the physician's ability to be faithful to the basic commitment at the heart of medicine: to pursue the good of the patient. Again, as Card. Bernardin has noted so powerfully, in many ways medicine has lost its moral compass. Catholic healthcare organizations must be places where physicians and *all* caregivers find a home, places where nothing impedes acting in light of their primary, covenantal obligations.

Deepen Understanding of and Commitment to Healthcare as a Social Good

The fourth challenge, and perhaps the most difficult, pertains to how we understand healthcare. The Catholic tradition holds that access to basic healthcare is a fundamental human right because health is a necessary condition for human well-being and flourishing. We insist, therefore, that healthcare never be considered a mere commodity. It must always be regarded as a social or public good rendered on the basis of need rather than ability to pay. Moreover, the primary motive for offering healthcare must never be to return profit to disinterested investors.

We can be proud as a Church, as a ministry, and as an association of our efforts toward systemic healthcare reform. Though many people believe the moment is not right to return to this issue, the millions of persons who lack access to effective, basic healthcare cry out for our assistance. On their behalf, we must act soon and we must act decisively. To do so, however, we will have to regain the trust of many Americans who have grown skeptical of the healthcare system and of us who are part of it. Dick Davidson of AHA has made the same point. He has said that if we are to regain the trust we seek, then we must be more tightly connected to the communities we serve. He is right. And what he is saying is quite Catholic. Our strength is in the local, in the communities called parishes that gather us to break open the Word and to share the Bread of Life. If anyone knows how to be local, we do. In focusing on the local, we must be certain that our actions convince those we encounter that we truly are committed to the persons and the communities we claim to serve. Thus our corporate structures must never grow so large that we lose sight of the faces of people in need. Never so removed that we can no longer hear the voices of those asking us for help. Never so complex that we disregard the fact that our roots are in the local community and that we exist today, in large part, because of the continued support of the community.

Why do I speak of lack of trust and community involvement in the context of systemic healthcare reform? I do so because I suspect that when we think of our advocacy efforts that carry forward the Gospel imperative to transform society, we think more readily of macro issues such as systemic healthcare reform. While such efforts are needed, they are only one prong of what must be a two-pronged effort. The second prong has to do with how we transform local markets, and that begins with how we carry forward the business dimensions of our ministry. The task of bringing about systemic healthcare reform must begin with the transformation of local markets. The theme of this year's assembly, "Mission in the Marketplace," addresses the way we do the "business of healthcare" as a means of bringing about such transformation. But this is a beginning and we have such a long way to go.

Before moving to the final section, I want to note several other challenges without any comment. I raise them not as an afterthought, but as a reminder of their importance to the ministry:

- How do we work with others so that compassionate care for the dying will eliminate the perception that physician-assisted suicide should be legalized?
- How do we better tell the story of how communities benefit from our presence so they will not fear our expansion?
- How do we partner with integrity with others who do not share all our values when market forces seem to make this necessary?
- How do we relate with integrity to for-profit ventures and publicly traded, investor-owned companies while preserving the fundamental nature of healthcare as a social good that is best carried on in the not-for-profit or voluntary sector of society?
- What will be the source of capital as we continue to "reengineer" the ministry?

Three Actions

Obviously, these challenges are demanding. In this final section I propose three action steps that we can take together as we pursue these continuing challenges. I believe they will provide a framework for engaging the challenges we face. The first two I have already discussed in *Health Progress* articles ("Toward a Common Vision for the Catholic Health Ministry," March-April, 1998; "CHA: An Intentional Community," May-June, 1998).

Develop a Shared Vision

As I have mentioned, we need to develop an explicit shared vision that will provide the stimulus and direction for this ministry between now and the year 2005. Of course, we need not begin at ground zero. We can build on the landmark efforts of the 1988 report of the Commission on Catholic Health Care Ministry, *Catholic Health Ministry: A New Vision for a New Century.* As we further develop our shared vision, we must have in mind the future that we wish to pursue together. I ask that

we all commit ourselves to the work that will be needed to develop such a shared ministry vision.

Clarify Our Identity as an Association

As I said earlier, CHA is nothing if it is not its members. In light of this reality, your board of trustees is clear that CHA is not merely a trade association seeking to further its members' material self-interests. Because CHA is its members doing the ministry together, I have suggested that we think of ourselves as an "intentional community." We choose to come together to be and do more collectively than we are able to be and do individually. It is the Spirit who gathers us and enables us to aggregate the power of persons, ideas, and dreams to realize a future that otherwise would be beyond our grasp. I ask that over the next year we work more closely with one another to gain a better sense of who we are as the Catholic Health Association and to explore the implications of a greater sense of unity among us.

Justice and the Millennium

As a Church, we have been invited to prepare ourselves to celebrate our entrance into the Third Millennium. We approach this monumental moment realizing that because the Lord "was made flesh," dwelt in our midst, suffered and died on our behalf, rose from the dead, and gave us the Holy Spirit, these past 2,000 years have been very different from all other years of human existence. As we approach the new millennium, we ask what is left to be done to realize the promise of the reign of God—a reign that is marked by peace and justice that we are here to serve. We know, as Pope Paul VI reminded us, that there will be no true peace until there is first justice in our hearts and in our world. For this reason, the Church has designated 1999 the year of charity and justice as a way to prepare for this coming millennium. Since Catholic health ministry is called to be, as Jesus was, a presence of radical healing in the world, we should take an active role in these preparations.

Consequently, I am asking that over the next year we work together to ensure that our own ministry of healing, as well as the broader healthcare system in this nation, reflects a stronger commitment to justice. Much has already been done, but there is much yet to do. Please consider your interest in working on both the design and execution of this effort. In the next few weeks we will provide opportunities for you to make your interest known, in part through our website. Finally, I propose that as we come together in the final assembly of this millennium, we gather under the theme "Let Justice Flourish in Our Time."

Our Shared Gift

It is time to draw these thoughts to a close and prepare to celebrate the Eucharist. As we do so, I want once again to share with you my enthusiasm as I become part of this community that is the Catholic Health Association. What a great gift we have been given in being able to serve in this great ministry.

While ultimately it is the Triune God who is the origin and destiny of our shared enthusiasm, I believe God often transmits divine assistance through those who are around us. In closing, as we reflect on our challenges and our possibilities, let us look at who we are, let us return to the faces that constitute the ministry that CHA serves. Let us look lovingly, attentively, for the face of God.

As we do so, is it not true that while we come from different places with diverse structures, we share *a common passion* for safeguarding and protecting this ministry?

> We share a common passion for safeguarding and protecting this ministry.

Is it not true that while we face different challenges with diverse solutions, we *share a determination* that Catholic healthcare is essential to the nation, society, and culture we serve?

Is it not true that while we have unique histories and traditions and represent sponsors and systems rich in their own diversity, we *share a common responsibility* to be a "sign of hope" wherever and whomever we serve?

Faces. Faces imprinted with passionate, determined, and responsible expressions.

Faces that make real who we are as well as the more that CHA can become.

Faces that call forth from our hearts and souls the confidence "to claim the promises of our God, know the presence of Christ, and trust the work of the Spirit."

CHA Board of Trustees

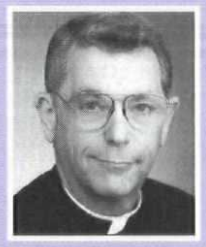
Pictured here are the members of the CHA Board of Trustees for 1998-99. Members who were elected at the June 8 business meeting are marked with an asterisk.

Chairperson
Sr. Doris Gottemoeller, RSM
President, Institute of the Sisters of Mercy of the Americas, Silver Spring, MD

Vice Chairperson
Michael D. Connelly
President/Chief Executive Officer, Catholic Healthcare Partners, Cincinnati

Secretary-Treasurer
Sr. Phyllis Hughes, RSM
Vice President, Healthy Community Initiatives, Mercy Housing, Inc., Denver

Speaker, Membership Assembly
David R. Lincoln
President/Chief Executive Officer, Covenant Health Systems, Inc., Lexington, MA



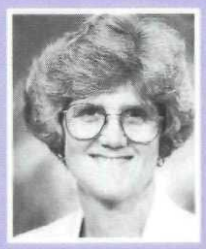
President
Rev. Michael D. Place, STD
President/Chief Executive Officer, Catholic Health Association, St. Louis

*Patricia A. Cahill, JD
President/Chief Executive Officer, Catholic Health Initiatives, Denver

*Jane Chiles
Executive Director, Catholic Conference of Kentucky, Frankfort, KY

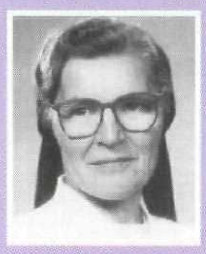
*Michael F. Collins, MD
President/Chief Executive Officer, Caritas Christi, Boston

*Charles J. Dougherty, PhD
Vice President, Academic Affairs, Creighton University, Omaha

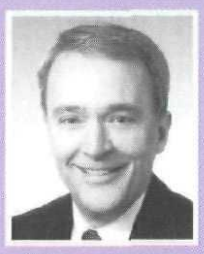


*Sr. Patricia Eck, CBS
Chairperson of the Board, Bon Secours Health System, Inc., Marriottsville, MD

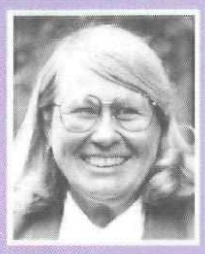
*Brian E. Forschner, PhD
Executive Director,
The Franciscan at St. Leonard,
Centerville, OH



*Sr. M. Therese Gottschalk, SSM
President, Marian Health System,
Tulsa, OK

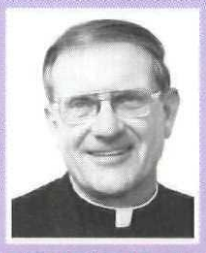


C. Kregg Hanson
President, Upper Midwest Region,
Catholic Health Initiatives,
Bloomington, MN

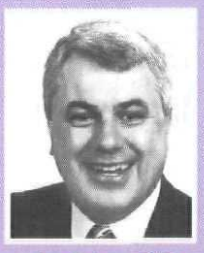


Else Marie Kiefer
Consultant, Catholic Healthcare
West, San Francisco

Sr. Jane Marie Klein, OSF
Board Chairperson, Sisters of St.
Francis Health Services, Inc.,
Mishawaka, IN

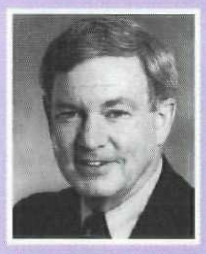


Bp. John J. Leibrecht, DD, PhD
Bishop of Springfield-Cape
Girardeau, Springfield, MO

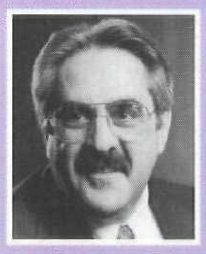


John S. Lore, PhD
President/Chief Executive Officer,
Sisters of St. Joseph Health System,
Ann Arbor, MI

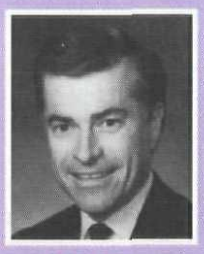
Sr. Kathleen Mulchay, SSCM
Provincial Superior, Servants of the
Holy Heart of Mary, U.S. Province,
and Board Chairperson, Provena
Health, Frankfort, IL



P. Terrence O'Rourke, MD
Board Chairperson, Centura Health,
Colorado Springs, CO

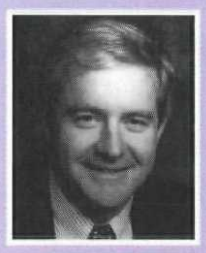


Robert E. Pezzoli
President/Chief Executive Officer,
St. Agnes HealthCare, Inc.,
Baltimore

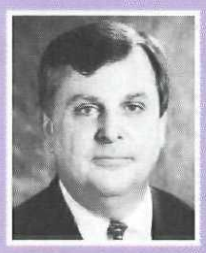


John T. Porter
President/Chief Executive Officer,
Avera Health, Sioux Falls, SD

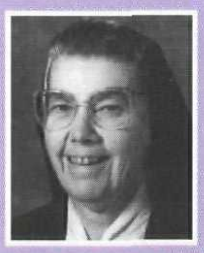
*Richard J. Statuto
President/Chief Executive Officer, St.
Joseph Health System, Orange, CA



Greg Van Pelt
Chief Executive, Providence Health
Plans, Providence Health
System/Oregon, Portland, OR



*Howard W. Watts
Executive Vice President, Catholic
Health East, Southeast Division,
Tampa, FL



Sr. St. Joan Willert, CSJ
President/Chief Executive Officer,
Carondelet Health Network,
Tucson, AZ

See you next year at the 84th Catholic Health Assembly in Orlando, Florida June 6-9, 1999