Sponsors Envision New Directions For Healthcare Ministry

At a recent symposium, sponsors of Catholic healthcare organizations affirmed their commitment to healthcare as an integral part of the Church's ministry. As they described their current challenges and articulated their vision for sponsorship in the year 2000, they exuded energy and enthusiasm for the new roles they can play as the U.S. healthcare system is reformed.

Questions for Sponsors

Alternative sponsorship, organizational structures, and the intricacies of forming partnerships topped the list as participants at the Catholic Health Association (CHA) meeting in January described their most pressing concerns. The sponsors, all from Catholic healthcare systems that have recent experience in responding to change, said arrangements with other Catholic and non-Catholic providers are raising a range of questions for sponsors to answer over the next six years.

Maintaining Catholic Identity How to maintain Catholic identity is only one of the tough questions, but a major one. Participants said they are struggling with how their organizations can continue their identity and influence in a healthcare system in which they deliver care at dispersed sites in collaboration with many organizations.

Once a partnership is established, transition plans need to include ongoing education in Catholic values and identity, noted Sr. Gretchen Elliott, RSM, president, Sisters of Mercy Regional Community of Detroit. Maintaining Catholic identity while respecting other facilities' religious heritage is a significant challenge, particularly in areas with pluralistic populations, added Sr. Phyllis Hughes, RSM, president, Sisters of Mercy Regional Community of Burlingame, CA.

Identity must be based on a clear vision for the organization. Sr. Mary Roch Rocklage, RSM, president and chief executive officer (CEO), Sisters of Mercy Health System, St. Louis, said her congregation asks itself how it wants to function. "The form must follow that. We don't start with the structure," she said.

Religious institutes must confront the barriers and congregational traditions that keep them from partnering with each other.

Sponsors must always remember that their ministry is a ministry of the entire Church, suggested Sr. Maryanna Coyle, SC, president, Sisters of Charity of Cincinnati. If they are to serve this ministry in the most effective way possible, religious institutes must confront the barriers and congregational traditions that keep them from partnering with each other, she said.

Leadership Development Values formation for persons at all levels of the healthcare organization is a keystone for the Catholic healing ministry, according to all participants. Sr. Elliott called for "an ever stronger program for the formation of healing ministers," including top managers, trustees, staff, and even parish health ministers. Sr. St. Joan Willert, CSJ, president and CEO, Carondelet Health Care Corporation, Tucson, AZ, recommended that the chief financial officer and the vice president for managed care be included in values formation programs, since they will assume increasingly important roles in administration.

As the sisters' presence in healthcare ministry declines, both laity and sponsors need preparation for the transition to a greater role for the laity in sponsorship. Sr. Nancy O'Connor, CSJ, general superior, Sisters of St. Joseph, Orange, CA, noted that about 22 percent of her congregation's active sisters are in healthcare, only 7 of whom are under age 50.

The group said sponsors need to talk more clearly with laity about sponsorship issues and determine the contributions laity can make with their gifts and commitment.

Defining "Sponsorship" According to participants, religious institutes must look at new definitions of "sponsorship." The difficult questions: Does sponsorship mean control of assets and ownership? Can sponsorship mean having presence and/or influence without ownership or control of institutions? Can the congregation continue its mission without ownership?

One thing was clear: Sponsorship will encompass ownership, partnership with the laity, or both on a regional basis.

Managed Care and Contracting "Managed care is driving us, but it can't be our identity," noted Sr. Rocklage. Her congregation concentrates on its mission of improving the health of communities by weighing three questions as it makes decisions: What is our social vision? What is our responsibility to our stakeholders, one of which is the poor? What is in our own best interest?

Managed care contracting and working with hospitals that have HMO (health maintenance organizations) plans, and the pressure to provide high-quality care at low cost, are key issues for her hospital system, said Sr. Willert. In Arizona, she noted, managed care penetration has risen from 10 percent to 90 percent in the past 5 years. At the same time, inpatient, acute care is shrinking (see "Institutional Health Services" in **Box**),

CARONDELET HEALTH CARE CORPORATION OF ARIZONA: CONTINUUM OF CARE

Institutional Health Services

Hospital
- Emergency (helicopter contract service)
- Burn center
- Inpatient rehabilitation and behavioral health
- Orthopedics
- Critical care cardiac program
- Medical-surgical
- Dialysis contract services
- Lithotripsy contract services
- High-risk obstetrics and nursery
- Social services
- Organ bank

Subacute Services
- Hospital based
- Nursing home based
- Skilled care
- Rehabilitation

Health Promotion and Disease/Illness Prevention Care

Family Services
- Natural family planning
- Prenatal clinics
- Normal obstetrics
- St. Elizabeth Clinic
- Level 2 nursery
- Breastfeeding clinic

Preschool Services
- Casitas Child Care
- El Rio Immunization

School Site Services
- Health screening
- Tucson Unified School District speech and language
- Health students

Worksite Services
- Occupational health
- Employee assistance plan
- Helping Hands
- Offenders Workoff

Southeast Arizona Community Health Centers
- Community Nursing Organization Healthy Seniors Project
- Senior health services
- High-risk senior nursing case management
- Home health transitional services
- Multidisciplinary health education
- Specialty services (advance directives, diabetes, enterostomal therapy, MS exercise program)
- Transportation

Primary/Specialty Care

Long-Term Care
- Meals on Wheels
- Hospice

Physician Practice
- Developing physician-hospital organization (in process)

Outpatient Services
- Early Admission Surgical Experience
- Specialty clinics
- Outreach
- Diagnostic centers (imaging, mammography, DMS/IV therapy)

Transitional Care

Outpatient Rehabilitation and Behavioral Health
- Certified Outpatient Rehabilitation Facility (speech and language, day rehabilitation, vocational rehabilitation, support programs)
- Mental illness and substance abuse
- Transportation

Extended Care Facility
- Holy Cross
- Holy Family (Alzheimer's unit)
- Institutionally based respite

Community Health Services

Business Affiliations
- Mercy Care Plan
- FHP (HMO)
- Intergroup of Arizona committees
- Arizona Department of Corrections

Community Support
- Centurions
- YACHT Club
- Foundation
- Volunteers
- Pastoral care
- Auxiliaries
- CARES (senior membership organization)
- Mission effectiveness
- Emergency phone support system

Community Participation
- Education (Willcox Hospital)
- Local, state, national organizations
- Donations to Red Cross, etc.
- Equipment/expertise donation to missions

which provides sponsors with more opportunities to go into the community. Carondelet Health Care Corporation has established 19 wellness clinics in communities throughout southern Arizona.

Regionalization Carondelet Health Care places priority on collaborating within a region through joint ventures and other affiliations, Sr. Willert said.

Catholic Health Corporation (CHC), Omaha, has also worked toward regional networks, since the late 1980s, added CEO Diane Moeller. Moeller said networking and regionalization must make sense for the market because "you can't change the market." Moeller said CHC concentrates on putting facilities together in groups where they are an equal partner with a defined role. CHC is also assessing "whether you can separate from an institution and still retain influence in a market," she said.

Networking and regionalization must make sense for the market.

Future of Multi-institutional Systems How regionalization will affect CHC is an open question, according to Moeller. "If we do everything right, we may have more work than ever," she speculated.

Carondelet LifeCare Corporation, St. Paul, MN, is also questioning the role of national versus regional healthcare systems. The organization's president and CEO, Sr. Mary Madonna Ashton, CSJ, said the sponsorship boards have relinquished some reserved powers to local boards, and the congregation seeks ways to have more active influence rather than to exert control. For example, a sister board member of the regional system is chairperson of the system's mission effectiveness committee.

Sr. Rose Mary Pint, OSF, chairperson, Wheaton (IL) Franciscan Sisters, anticipates changes at the corporate level of Wheaton Franciscan Services, Inc. Corporate staff should include a physician and an insurance expert, as well as persons who can orchestrate collaboration. A person in the "transformation function"

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Sr. St. Joan Willert, CSJ
President and Chief Executive Officer
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will be needed to ensure collaborations integrate mission and leadership development. Sr. Pint said the system is currently involved in six collaborations, involving non-Catholic and Catholic hospitals and other religious congregations.

Church Relationships Relating to the institutional Church and communicating with their bishops concerns sponsors. Ventures with non-Catholic providers are motivating sponsors to find ways to help bishops understand the ethical issues involved. Discussing issues one-on-one was suggested as an effective way to communicate with the local bishop.

Participants see an increasing need to coordinate work with parishes to help local churches assume responsibility and play a greater role in the Church's healing ministry.

Vision for the Year 2000

Despite these concerns, symposium participants envisioned a courageously hopeful role for the healing ministry of Jesus in the year 2000—a time when they think healthcare reform that includes a basic benefit package for all citizens and a high degree of capitation will have been enacted. The ministry will have the following characteristics:

- Diminished institutional, acute care presence accompanied by more primary care and responsiveness to people's needs wherever they gather—neighborhood clinics, parish centers, shopping malls, migrant worker camps, schools. A healthier society in which the Catholic healthcare ministry has taken the lead in responding to social problems like violence and homelessness.
- Catholic providers functioning in networks with other providers, their fortunes dependent on the success of the network and their position within it.
- Sponsors with more power and influence to promote the common good. Religious congregations contributing significantly because of their history of responding to need and experiencing renewed energy as they interact in efforts that creatively actualize many dimensions of health and wholeness.
- Sponsors and laity in integrated partnerships and increased participation of parishes and communities in the healing ministry.
- Most healthcare spending allocated toward promoting health and well-being, rather than acute care.
- Decreased duplication of high-technology services as providers within a community cooperate in strategic planning.
- Emphasis on community-based care, with healthcare personnel, social workers, and educators acting as catalysts for an interdisciplinary approach to health.

A person in the "transformation function" will be needed to ensure collaborations integrate mission and leadership development.

- Information systems that provide patient records at multiple sites of care.
- Employees and trustees who take responsibility for mission, as reflected in their orientation and performance evaluations.
- Healthcare workers with higher satisfaction and less burnout, and more equal remuneration among care givers because of the Catholic ministry's influence.

Ministry in Transition

"Is this vision possible to achieve or too idealistic?" participants wondered. Most anticipate a transition period—and not an easy one—before the vision is reached.

"To achieve some of these things, I think there's going to be a terrible struggle internally within the Catholic system. Who's going to survive and who isn't?" said Sr. Ashton. She suggested that CHA lead in bringing sponsors together in cosponsorship arrangements that will be a step in the transition to the vision. The strength of many religious congregations working together in regions can have an influence that keeps healthcare focused on quality of care, not just the cost, she said.

Reflection on Ministry CHA must also challenge sponsors to reflect on why they are in the healing ministry, Sr. Coyle said. They must consider whether they should continue as individual sponsors, move forward in cosponsorship or other partnership arrangements, or relinquish the ministry.

"This is the opportune time for sponsors to look at governance structures and whether they facilitate the system's and the institution's ability to be an active participant with others for the future of the ministry," she added.

Ecumenical Sponsorship Consolidation within the ministry and the ascendance of for-profit hospitals are forcing such reflection. If, as Moeller predicted, half of Catholic hospitals could close by the end of the century and only a fourth of religious institutes remain in the institutional ministry, a whole new approach for sponsorship will be needed. Individual religious sponsorship, grounded in reimbursement for acute care, has become a shackle that blocks the vision of a transformed healthcare system, she said.

Educating the Community For the civic community, choosing a better healthcare system often means giving up more visible benefits such as jobs, Moeller said. The group agreed that education to change society's values is critical to effect change. As Ann Neale, vice president for advocacy and corporate ethics, Franciscan Health System, Aston, PA, put it, "There are tremendous cultur-

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Coming in the Next Issue of

Health Progress

TRANSFORMATIONAL LEADERSHIP

In June, Health Progress *introduces the results of the Catholic Health Association's research project,* Transformational Leadership for the Healing Ministry, *which identified 18 differentiating competencies related to superior performance in Catholic healthcare leaders (see article on p. 68). Special section articles:*

- *Define various "clusters" of competencies and discuss what motivates leaders who possess them*
- *Explore applications of this model for excellence, including implications for sponsors, trustees, and executives*
- *Highlight the role of Catholic healthcare executives as servant-leaders*
- *Present executives' views about the opportunities and barriers associated with collaboration and consolidation*
- *Urge healthcare leaders to sustain excellence at the microscopic level by "honoring operations"*

ANALYSIS

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Primary care initiatives are proliferating.

al values that fly in the face of the direction we're moving: individualism, freedom of choice, 'more is better.' What a community wants may not correspond to its genuine needs."

REALIZING THE VISION

Despite obstacles, Catholic healthcare has already taken pragmatic steps along the path participants envision. Sr. Pint pointed out that lay and religious are already sharing in sponsorship in some places and many organizations are consolidating their tertiary services and forming integrated delivery networks and advocacy and computer networks. Patient- and community-focused primary care initiatives are proliferating rapidly throughout the ministry (see *Health Progress*, January-February 1994).

Catholic healthcare can fulfill its role as a prophetic voice that speaks out for the poor and on ethical issues, participants suggested, if sponsors work together. "I don't think coming together is optional for Catholic healthcare at this point. If we don't, we will dissipate our influence, our ability to bring that prophetic dimension to the broader healing ministry," said Sr. O'Connor.

By having a vision, Catholic sponsors can influence the direction of healthcare and find a renewed sense of hope and commitment. Sr. Coyle noted, "The everyday struggles aren't going to go away, and some relinquishment is necessary, but at the same time new initiatives are going to occur. And we have the resources for those initiatives. The resources aren't measured by numbers of people or dollars, but by our original motivation and our heritage." —*Judy Cassidy*

HEALTH POLICY

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plan might have a smaller employer share than the 80 percent share the Clinton plan envisions, and perhaps more flexibility and a longer phase-in period for the smallest businesses.

Whether Congress is prepared to pass legislation that meets the goal of universal coverage or whether it will merely provide incentives for or improve access to healthcare coverage will be the crux of the debate. Senate Republican staffers in conversations have revealed willingness to work toward universal coverage. Said one staffer, "There are 20 to 30 Senate Republicans who want universal coverage. There's more that we do agree on than don't."

It is time for Congress to work together to forge a bipartisan compromise that will place the United States among the rest of the industrialized nations that ensure healthcare coverage for their citizens. As Mrs. Clinton commented in February, "How we handle healthcare reform will tell much about who we are as a nation." □

NOTES

1. Edward G. Grossman, "Comparing the Options for Universal Coverage," *Health Affairs*, Spring II, 1994.
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3. C. Eugene Steuerle, "Implementing Employer and Individual Mandates," *Health Affairs*, Spring II, 1994.
4. Mark V. Pauly, "Making a Case for Employer-enforced Individual Mandates," *Health Affairs*, Spring II, 1994.
5. Karen Davis and Cathy Schoen, "Universal Coverage: Building on Medicare and Employer Financing," *Health Affairs*, Spring II, 1994.
6. Sheila Zedlewski, John Holohan, and Colin Winterbottom, "The Clinton Health Plan: Who Would Pay?" Urban Institute, Washington, DC, February 1994.
7. Frank B. McArdle, "How Would Business React to an Employer Mandate?" *Health Affairs*, Spring II, 1994.