

# Catholic Health Initiatives at 10

## The Denver-Based System Was the First to Involve Laypeople in Sponsorship



**BY JOYCE M. ROSS**  
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**T**he summer of 2006 marked an event that affirmed an act of faith: the 10th anniversary of the formation of Catholic Health Initiatives (CHI), the nation's second-largest Catholic health care system.

Formed in 1996 as the result of the merger of three Catholic health care systems, and soon joined by a fourth, CHI broke new ground. The system integrated a diverse collection of health care facilities previously sponsored by 12 different religious congregations. It was also the first Catholic health system to give laity a sponsorship role in its facilities.

"The formation of CHI was an act of faith, because it was done without the standard business practice of due diligence," said Kevin Lofton, the system's president and chief executive officer. "The sisters who formed the Steering Council that created CHI made it clear that they were willing to take that risk in creating the new organization."

Paul Neumann, now senior vice president and general counsel for CHI, served as outside counsel to the three founding systems during CHI's formation. "In my opinion, had there been due diligence, the deal would not have been done," he said. "The sisters were guided by the Holy Spirit."

The sisters' determination to merge their health ministries created a need for staff to do whatever was necessary to make CHI work, despite the fact that doing so involved dozens of facilities of various types and sizes, in different states of financial health. "That was the start of CHI being an innovative organization that finds new ways to improve," said Lofton.

Today, Lofton said, the system is stable, strong

and poised to grow. "CHI has navigated some rough waters and has become stronger for it," he noted. "It always helps that we are grounded in our core values and in the mission and vision of the sisters."

In fact, when faced with a difficult decision or an uncertain path, CHI's leaders often revisit documents that describe the intended direction for the system. Colleen Scanlon, JD, RN, senior vice president of advocacy, refers back to the organization's first strategic plan, approved in May 1997. "It reminds me that, in terms of advocacy, the focus wasn't just on governmental relations. The sisters wanted CHI to be responsible stewards of our finances and of the Earth; to work for justice for employees as well as those served; and to have congruence between what we say and how we act," she said. "Making this real is up to us, and we owe that to our foundresses, to ourselves, and—most importantly—to those we serve."

### CREATION OF A NEW STRUCTURE

CHI was formed from Franciscan Health System, Aston, PA.; Sisters of Charity Health Care Systems, Cincinnati; and Catholic Health Corporation, Omaha. "The three could not have been more different from each other," said Michael Fordyce, CHI's chief administrative officer. "Franciscan Health System had the most systemlike structure, Catholic Health Corporation was a much looser confederation, and Sisters of Charity Health Care Systems was somewhere in between." About a year after CHI was formed, the Sisters of Charity of Nazareth Health System, Nazareth, KY, joined as well.

CHI's facilities are sponsored by a public juridic person, the Catholic Health Care Federation (CHCF). The same people who sit on the system's board (called the Board of

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Stewardship Trustees) also constitute CHCF. They are thus responsible for *both* governance and sponsorship.

Why did CHI create this model of sponsorship? "The congregations wanted to ensure the continuing Catholic identity of the health ministries they started, and, at the same time, wanted greater lay involvement in leadership of those ministries," said Sr. Peggy Martin, OP, JCL, a Steering Council member who is today CHI's senior vice president of sponsorship and governance. "Establishing a new public juridic person for the ministries, which would sustain their Catholic identity in perpetuity, and structuring the members of the juridic person to include both laity and religious met both goals," she said.

Establishing the public juridic person was a long and complex task. "CHCF was actually established in 1991 by one of CHI's predecessor systems, Catholic Health Corporation of Omaha," said Sr. Peggy. "It took 11 years to establish CHCF. It took so long because Catholic Health Corporation was sponsored by multiple congregations and had facilities in multiple dioceses. That complicated the issue of which church authority should create the public juridic person."

Eventually, the church determined that Catholic Health Corporation's public juridic person should be pontifical, accountable to the Congregation for Institutes of Consecrated Life and Societies of Apostolic Life in Rome. CHCF in 1991 became the first pontifical public juridic person in health care in the United States. In 1996, when CHI was formed, CHCF became the sponsor of all the facilities in the system.

Part of CHI's sponsorship model was a requirement that the congregations complete the transfer of their properties to CHCF within five years. "There was also a 'no exit' strategy," said Sr. Esther Anderson, OSF, PhD, a member of the Steering Council and the second chair of CHI's Board of Stewardship Trustees. "It was very important for the congregations to embrace the sponsorship model and make a complete commitment to forming CHI. That commitment has been one of our tremendous strengths, and enabled us to make significant progress toward becoming one organization in a very short time."

Some members of CHI's first Board of Stewardship Trustees had been on the boards of

the predecessor systems, some were new, and some had been members of the Steering Council. However, as members of CHI's board, they took a forward-looking stance. "From day one, the Board of Stewardship Trustees acted as the board of this new organization," said Neumann. "They no longer thought about the prior systems, but about the new entity."

"No board member ever talked about 'the way things used to be,'" said Fordyce. "They knew it was important to make decisions that were right for CHI, and not to base those decisions on past history. They were, and are, extraordinary people."

Serving as sponsors "was a significant new experience for the board," said Sr. Maryanna Coyle, SC, the board's first chair. "Previously, all sponsorship responsibilities had been held by religious congregations. CHI's board, which includes members of religious congregations and laypersons, is responsible for both governance and sponsorship; in other words, they have both civil and canonical responsibility for CHI. It was, and continues to be, a solemn experience for new members of the board—especially laity—to take the canonical oath as members of CHCF. In doing so, they promise to reflect Catholic values and, in particular, to remain aware of the needs of the poor and underserved."

It took time for the board's members to become accustomed to the fact that they—not the religious congregations—now sponsored CHI's health care facilities. "It took a few years for the board members to become comfortable wearing the mantle of sponsorship," said Neumann. "It took time for people inside and outside the organization to understand that the congregations still have influence over Catholic Health Initiatives, but they no longer sponsor its ministries."

### SHAPING A NEW CULTURE

CHI's staff, led by its first president and chief executive officer, Patricia Cahill, quickly took steps to help the new system begin to coalesce, establishing a single, systemwide pension plan, debt policy, and so forth. However, challenging though it was to merge the policies and procedures of the three systems, even more challenging was the creation of a single, systemwide new culture.

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'felt' the way they did when they were sponsored by the religious congregations," said Neumann. "Ten years later, they feel like CHI facilities. When it comes to culture, things don't happen quickly. It took time for employees in our facilities to feel like part of CHI."

An essential step in the development of CHI's culture was the involvement of employees in the identification of its core values: reverence, integrity, compassion, and excellence. "More than 700 people, from all levels across the system, took part in the process of naming the core values," said Fordyce. "We made the process as inclusive as we could. The core values helped galvanize the organization. We have based the development of many important tools, like our leadership development program, on the core values. They serve as a touchstone for our culture."

The creation of CHI's Mission and Ministry Fund also helped give the system an identity. This fund, whose principal recently reached \$100 million, was created through contributions from CHI facilities. It provides grants to programs that take an innovative approach to building healthy communities, a goal expressed in CHI's mission and vision statements.

CHI's original Steering Council also made some critical decisions that would help the new organization develop its distinctive culture. "The Steering Council decided that the chief executive officer of the new system could not be the chief executive of any of the predecessor systems," said Fordyce. "They also expected CHI to have its own culture, not to adopt the culture of one of the predecessors. Those decisions, plus appointing a brand-new board, really set the stage for a new day."

#### **READY FOR GROWTH**

As CHI worked to build a culture, it also undertook structural change. "The sisters provided a vision for the structure of CHI, but few details," said John DiCola, senior vice president of strategy and business development. "The Steering Council left it to those who would manage CHI to fill in the details, and we focused on creating stability and strength."

CHI gradually evolved into a flatter structure, eliminating regional offices in favor of two levels of operations, national and local. The organization also determined that some facilities would be

better able to serve their communities if they were aligned with other partners and transferred them to new owners. Still, CHI remains diverse, comprising both critical access hospitals in remote rural areas and major urban medical centers. CHI also includes long-term care facilities, assisted living centers, and residential facilities.

"We have many medium or small facilities spread out across a large geography, including a significant number of rural markets," said DiCola. "We also have some larger facilities in major markets and have worked to ensure that those facilities are strong and well-positioned. Now we're looking at opportunities to grow both our existing and new markets, particularly with Catholic systems or stand-alone facilities that would be a good fit with CHI."

To help the system grow, CHI recently took a fresh look at its unique model of sponsorship. The congregations that formed the new system envisioned a shared model of sponsorship, with equal participation by religious persons and laypersons. In forming the system, the Steering Council specified that half the members of the Board of Stewardship Trustees would be members of religious congregations and half would be laypersons. Today, however, CHI is ready to be flexible in its sponsorship model. "Some congregations may want their health care facilities to become part of CHI but are not ready to alienate their properties or to fully embrace its model of sponsorship," said Sr. Esther. "The Board of Stewardship Trustees believes CHI has created enough stability to allow variations in that model."

"We can provide flexibility as to how a hospital or system comes in to CHI, and different levels of participation in the sponsorship model," said DiCola. "Our board has encouraged us to be creative."

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#### **EMBRACING CHANGE**

Change was a constant drumbeat in CHI's early years. At the decade mark, change has taken on a new role within the organization—as an asset that can be managed to help drive further innovation.

"As we continue to integrate into one system, we have had to look at how to make change more

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beneficial and more effective,” said Lofton. “Change in our organization is not so much about realigning processes and responsibilities as about helping our employees redesign what they do in order to better serve our patients and communities. So we are implementing a systemwide change-leadership methodology that will bring a consistent, disciplined approach to managing change and encouraging our people to try new things.”

Another recent change at CHI is a new emphasis on research and development. In fact, the system recently created a new position, vice president of research and development. “CHI doesn’t have academic medical centers equipped to do bench research,” said Lofton. “But our diverse system has an excellent capability of determining how a product or protocol works in a variety of settings—in a community hospital, a long-term care facility, or independent living facility.”

For example, CHI recently received a \$145,000 grant from the Robert Wood Johnson Foundation to support the implementation of rapid-response teams throughout the system. (See Jane Braaten, et al., “Saving Lives at Centura,” *Health Progress*, November-December 2006, pp. 64-67). This highly successful effort contributed to a reduction in mortality throughout the system and also identified challenges faced by smaller, rural hospitals, in which providing coverage for rapid response team members can be more difficult than in larger urban facilities.

Mary Wakefield, PhD, chair-elect of the Board of Stewardship Trustees and director of the Center for Rural Health at the University of North Dakota, Grand Forks, ND, believes CHI has great potential, especially because of its rural presence, for helping to develop and test new products and new models of care. “Many people think of the flow of ideas in health care going from larger urban facilities to smaller rural facilities, and this is often true,” she said. “But the flow of ideas can be just as valuable the other way. Because rural facilities often must be very

resourceful in their provision of care to individuals and communities, they can contribute solutions and ideas suitable for much larger organizations. CHI is fortunate to have that kind of diversity.”

### **LIVING THE MISSION**

The people who created CHI and nurtured it during its first decade give it high marks for faithful adherence to its mission. Even so, they acknowledge that there is always more work to be done.

“Our foundresses established the transformation of health care as an essential element of our mission,” said Lofton. “It’s right at our core. During the first 10 years of CHI, we built a solid foundation that will enable us to do more to achieve that kind of systemic transformation.”

Sr. Esther believes that, at a time when the number of people without access to health care is growing, the values-based health care provided by CHI is more important than ever. “CHI will always be a work in progress, but I feel we are really accomplishing what we hoped to,” she said. “It’s a fluid organization that is willing to take risks to ensure that Catholic health care continues into the future.”

Neumann recalls the formidable will of all of the sisters who formed the Steering Council. “These women were incredibly brave and able to see the future,” he said. “One thing that CHI does very well is to orient our leaders to the legacy of the sisters. We make sure that part of our orientation process is remembering where these ministries started and that they are ministries first, businesses second.”

“During our next 10 years, as in our first 10 years, we will focus on what’s possible, not on the way things have always been done,” said Lofton. “We are the guardians of the heritage of the sisters, and through their guidance and faith we have become architects of the future of the healing ministry.” ❧

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