

Catholic Identity and the Reshaping of Health Care

By MICHAEL PANICOLA, PhD and RON HAMEL, PhD

Health care in the United States is in a state of major transformation, the likes of which perhaps we have never seen. In the volume-to-value transition, payers already are beginning to adopt value-based reimbursement models; employers are demanding more return on their considerable investment in employee health; providers are consolidating in strategic partnerships; consumers are becoming more cost-conscious; start-ups and deep-pocket technology companies are challenging the status quo; and advocates for price transparency are exposing the irrationally wide variation in health costs.

This transition reveals some very encouraging trends. The shift to population health brings wellness, prevention, coordinated care and chronic disease management to the forefront. Improved delivery structures and a better alignment of financial incentives toward value and away from volume are in evidence. More heartening, the number of uninsured Americans continues to drop due to the improving economy, Medicaid expansion and health care marketplaces offering affordable plans for individuals and families. Such encouraging trends have special resonance for Catholic health care: The promise of creating a more just, sustainable health care system in line with a Catholic-Christian vision of health care has the potential for strengthening Catholic identity.

There are, however, trends that are concerning. While the percentage of uninsured people is declining, the number of those underinsured is increasing. Almost 40 percent of indi-

viduals under 65 years of age now have a high-deductible health plan, which means that while they have health coverage, they may not have the funds to reach the deductible, forcing them to

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forgo care or needed medications. The problem stretches beyond low- and moderate-income individuals, so that in the majority of U.S. households, the percentage of income that goes to pay health care costs is still on the rise.

Health care providers have challenges of their own. The health care sector overall, and not-for-profit health systems in particular, have rising expenses with weaker reimburse-

ments, which pushes down operating margins.¹ This has led, in part, to a rash of mergers and acquisitions whereby highly capitalized, larger health systems get stronger, while less-capitalized, smaller health systems and freestanding hospitals, especially rural and critical

access hospitals, get weaker. Catholic mega-systems have revenues close to or surpassing those of for-profit systems, and it is difficult to keep abreast of the proliferation of Catholic and non-Catholic partnerships.

Rapid consolidation is not unique to health care — think banks, airlines, cell phone carriers and car manufacturers. As many financial analysts tell us, consolidations may be necessary, because size and scale are critical for future success. Still, Catholic health care never has been in this for the money or merely to survive. It always has been, and still should be, about furthering the healing ministry of Jesus by living out our fundamental value commitments, which are the true measure of our identity and at stake in every merger, acquisition and partnership. We must ask ourselves if we are considering the impact on identity when Catholic health care is being reshaped in unprecedented ways. In our desire to ensure long-term sustainability, are



we chasing the market and disregarding the impact this could have on identity? Are we asking how growth opportunities further our ability to live out our fundamental value commitments, or are we focusing merely on the narrower cooperation issues that could derail the transaction?

FUNDAMENTAL VALUE COMMITMENTS

Catholic health care is motivated and defined by its faith in the redemptive act of Jesus Christ. Its mission is to reveal God's healing and reconciling presence to the sick and suffering of the community. Rooted in the Gospel, our values are expressed in the organizational documents of Catholic health ministries and make up the substance of the Catholic Health Association's "Shared Statement of Identity."

As we pursue new business arrangements, we must ensure we are truly advancing the mission of Catholic health care. This requires that we remain vigilant and deliberate about our fundamental value commitments and about who we are as ministry. An added reason to do this is the call of Pope Francis, who has challenged the entire Catholic-Christian community to a deepened living out of the Gospel values. The pope has taken up certain themes that reorient us to core aspects of our fundamental value commitments, and they must be taken into account when considering a merger, acquisition or partnership.

The first theme is that of mercy and hope. From the beginning of his

papacy, Francis has preached that the church mediates God's love of humanity by being a sign of mercy and hope, especially to people who are suffering, lost and in need of help. To be that sign of mercy and hope, Catholic health care must locate itself in the midst of suffering and minister to those who suffer. This is what we are weighing when considering a new business arrangement — whether the merger, acquisition or partnership gets us closer to the suffering that needs God's mercy and hope. Are we looking at whether the reconstituted health system and the services it offers will further our ability to reveal God's healing and reconciling presence to the sick and suffering of the community?

Pope Francis' second theme is that of care for the poor. Perhaps more than any pope in recent history, Francis is intimately familiar with and committed to the plight of the poor among us. Indeed, he has said he wants a "Church which is poor and for the poor." The significance of the pope's insistence on the preferential option for the poor in Catholic health care cannot be mistaken. The poor need to be a primary focus of our ministry if we are to be true to our mission. Any organizational decisions we make — about community services, consolidation of jobs or new business arrangements — have to be considered in light of their impact on the poor. If the best business deci-

sion is the wrong ministerial decision, we have to look for another way. When we seek to acquire, merge or partner with another organization, are we asking how the new business arrangement will further our ability to care for the

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poor? Are we looking to go into medically underserved communities, especially rural and inner-city areas, or are we only considering growth opportunities with prospective partners that have significant revenues, positive margins and good payer mixes?

The third theme is that of social justice. While continuing to address traditional moral issues, Pope Francis has raised our awareness of the profound issues of poverty, racial inequality, income disparity, climate change, trafficking and migrants/refugees as subjects we must engage if we are to broaden the scope of our moral life.

The emphasis on social justice is important for Catholic health care in three ways. First, we need to be models of justice within our own organizations in terms of how we treat our employees, care for our patients, and act as corporate citizens in terms of the investment of our substantial resources and our care for the environment. Second, we need to be a force for good in our communities by advocating for justice and working with others to undo and correct injustices. Finally, we need to be aware of the broader social justice issues engendered by new business arrangements and attend to these as much as we attend to issues related to

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cooperation. Do we look at how a merger, acquisition or partnership will affect employees' job stability, wages and benefits? Do we consider the impact on local communities and the increase in our environmental footprint when we expand the size of our systems? Are we able to evaluate the prospective partner from a moral perspective that extends beyond their involvement in abortion, contraception and sterilization?

DISCERNMENT AND INTEGRATION

As we continue to reshape the ministry of Catholic health care, we must never let the need for size and sustainability blind us to the importance of our fundamental value commitments. Living out these commitments is a necessary condition for realizing our mission of revealing God's healing and reconciling presence to the sick and suffering of the community. Consequently, every new business arrangement undertaken by a Catholic health care organization must be evaluated on the basis of whether it allows us to live out these commitments.

Making this the case in new business arrangements is no easy task. It will take senior leaders who are cognizant of, sensitive to and willing to stand up for the value commitments when it might be easier to set them aside in the interest of closing the deal. It is going to take a better, more systematic approach or process to discernment on the front end and integration on the back end.

To address the concern around mission/ethics discernment and integration in new business arrangements, we outline the following process for consideration, with the caveat that it be taken as a first attempt that others within Catholic health care will refine, expand upon and adapt to the unique circumstances and cultures of their organizations. Engaging the process will not guarantee every merger, acquisition or partnership we enter into will advance the Catholic health care mission. However, it will ensure that we ask necessary questions for understanding our motivations and that we keep our fundamental value commitments at the center of our decisions.

When a Catholic health care organization — often abbreviated to CHCO — is considering entering into a formal business arrangement, especially with an other-than-Catholic party (organization, physician or other individual), senior leaders must be sure that:

- The business arrangement furthers the CHCO's vision and mission (this applies also to

arrangements with Catholic parties)

- The prospective partner is compatible with the CHCO from a values perspective or, at a minimum, is not engaged in activities that are notably inconsistent with the CHCO's value commitments

- The CHCO's value commitments are adopted at a level proportionate to the facts and circumstances of the particular business arrangement

- The business arrangement meets cooperation guidelines, and any medical interventions with restrictions are acceptably structured or carved out

- A mission and ethics integration plan is developed prior to the close of the transaction and implemented effectively thereafter

The process and timing for ensuring these critical features are met should be sequenced in three phases: (See **Appendix I** for accompanying graphic.)

Phase 1: Assess (a) ability to further the CHCO's vision and mission, (b) compatibility with the CHCO's values, and (c) level of adoption of the CHCO's value commitments.

This phase is the most important in any discernment about a new business arrangement, and it should be the first order of business — even before financial and legal discussions. The focal points in this phase are whether and to what extent the business arrangement will further the CHCO's vision and mission; whether the prospective partner is compatible with the CHCO from a values perspective; and at what level should the CHCO's value commitments be adopted in the business arrangement.

During their discernment, senior leaders should ask and reflect upon these questions to reach a conclusion about whether the contemplated business arrangement will further the CHCO's vision and mission.

- Will it enable the CHCO to increase access to care, especially for the uninsured and those in economically, physically and socially marginalized communities?

- Will it enable the CHCO to improve community health as defined by key metrics related to mind, body, spirit and environment?

- Will it enhance the CHCO's ability to improve the patient experience, manage the health of populations and lower the total cost of care?

- Will it improve the CHCO's financial position and its ability to reinvest in the communities it serves?



If the answers to these questions are “yes,” senior leaders may proceed to the second part of this phase.

If the answers are “no,” generally the business arrangement should not be pursued. However, in limited situations, there may be some circumstances whereby the CHCO’s senior leaders choose to discern further — perhaps because the business arrangement may be worth pursuing for the overall good of the ministry, or perhaps they want to proceed cautiously to determine if the arrangement can be restructured.

Regarding compatibility with the CHCO’s values, senior leaders need ask only one question, and the answer must not be clouded by the desire to move forward with the business arrangement.

- Does the prospective partner exhibit evidence of living core aspects of the CHCO’s values or, at a minimum, of not being engaged in activities inconsistent with CHCO’s value commitments? (See **Appendix 2.**)

If the answer to this question is “yes,” senior leaders may proceed to the third part of this phase.

If the answer is “no,” the arrangement may still be pursued if the prospective partner is not engaged in activities that are notably inconsistent with the CHCO’s value commitments, or if the CHCO will have majority control of the new company and can ensure that its value commitments are adopted.

Discernment in this part of Phase 1 can be complicated. As a general rule, the greater the control the CHCO has in the new business arrangement and the more the prospective partner will be integrated with the CHCO, the higher should be the level of adoption of the CHCO’s value commitments.

At a minimum, the CHCO should seek to incorporate these value commitments into a new business arrangement whenever applicable:

- Creating a safe, just and diverse work environment and providing fair wages and benefits to all employees

- Protecting the sanctity of human life from conception to natural death. Actions such as direct abortion, assisted suicide, euthanasia and embryonic stem cell research are not permitted in a Catholic health care institution.

- Serving uninsured, underinsured, Medicaid and other vulnerable populations. For non-health care providers, this value commitment

may be addressed through community outreach and charitable programs that seek to promote the health and well-being of the local community, with special emphasis on those living in poverty and at the margins of society.

Phase 2: Identify cooperation issues related to ERD-restricted interventions

Before a definitive agreement can be signed, the CHCO needs to identify any cooperation issues that might arise in the new business arrangement with an other-than-Catholic party engaged in medical interventions with restrictions as defined in the *Ethical and Religious Directives for Catholic Health Care Services*. Beyond issues related to the direct taking of life, ERD-restricted interventions typically include contraception, sterilization and in vitro fertilization.

For ethical guidance on the major types of business arrangements that senior leaders should use for discussions with a prospective partner, see **Appendix 3**. A qualified and experienced ethicist must complete a formal analysis addressing cooperation issues before a definitive agreement is signed.

Phase 3: Establish mission/ethics integration plan

Before the definitive agreement is signed, system mission and ethics leaders should conduct an on-site assessment (if applicable) and document review to determine key integration opportunities based on the items detailed in **Appendix 4**.

The outcome of this phase should be a well-developed integration plan that clearly outlines the key mission and ethics components that will need to be developed under the new business arrangement, including a timeline, communication plan and a list of responsible parties that corresponds to each action item of the plan.

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NOTE

1. See, for instance, Robin Respaud, “Grim Outlook for Healthcare, Hospital Sector in 2015: Rating Agencies,” *Reuters*, Dec. 16, 2014.

Three Phases of Mission/Ethics Discernment and Integration in New Business Arrangements

PHASE 1: Assess ability to further CHCO's vision and mission, compatibility with CHCO's values, and level of adoption of CHCO's value commitments

A. Further CHCO's vision and mission (applies to all arrangements)

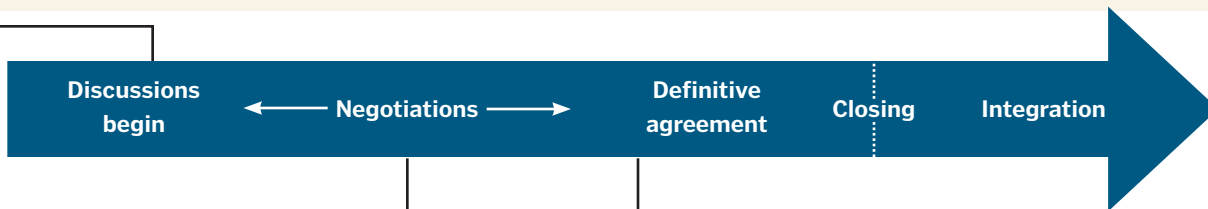
- I. Will this business arrangement enable CHCO to increase access to care, especially for the uninsured and those in economically, physically and socially marginalized communities?
- II. Will this business arrangement enable CHCO to improve community health as defined by key health indicators related to community health needs assessment?
- III. Will this business arrangement enhance CHCO's ability to improve the patient experience, manage the health of populations and lower the total cost of care?
- IV. Will this business arrangement improve CHCO's financial position and its ability to reinvest in the communities it serves?

B. Compatibility with CHCO's values

- I. Does the prospective partner exhibit evidence of living core aspects of CHCO's values or, at a minimum, is not engaged in activities that are notably inconsistent with CHCO's value commitments as outlined in **Appendix 2**?

C. Adoption of CHCO's value commitments

- I. To what extent should the value commitments of CHCO be adopted by the prospective partner? As a general rule, the greater the control CHCO has in the new business arrangement and the more the prospective partner will be integrated into and/or associated with CHCO, the higher the level of adoption of CHCO's value commitments. At a minimum, CHCO should seek to incorporate the following value commitments into a new business arrangement whenever applicable:
 - Creating a safe, just and diverse work environment and provide fair wages and benefits to all employees.
 - Protecting the sanctity of human life from conception to natural death. Actions such as direct abortion, assisted suicide, euthanasia and embryonic stem cell research are not permitted.
 - Serving uninsured, underinsured, Medicaid, and other vulnerable populations. For non-health care providers, this value commitment may be addressed through community outreach and charitable programs that seek to promote the health and well-being of the local community, with special emphasis on those living in poverty and at the margins of society.



PHASE 2: Identify cooperation issues related to ERD-restricted interventions

- A. Determine the type and extent of cooperation issues related to the provision of ERD-restricted medical interventions by the prospective partner.
- B. Assess willingness and ability of prospective partner to effect carve-outs for the specified business arrangement as outlined in **Appendix 3**.

PHASE 3: Establish mission/ethics integration plan

- A. Conduct on-site assessment (if applicable) and document review prior to closing in order to determine key mission and ethics integration opportunities based on integration components detailed in **Appendix 4**.

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APPENDIX 2

Fundamental Value Commitments

RESPECT · COMPASSION · EXCELLENCE COMMUNITY · STEWARDSHIP

Catholic health care is a response to Jesus' call "to go and do likewise." As such, CHCOs have a specific mission, especially to the poor and vulnerable, and are guided by certain values. While the list of values may differ somewhat among the various CHCOs, they tend to revolve around the values of respect, compassion, excellence, community and stewardship. In this ever-evolving health care context, CHCOs should welcome collaborative partnerships that support these core values and further the CHCO's ability to reveal God's healing and reconciling presence to the sick and poor of the community. CHCOs need to assess whether the prospective partner is compatible with the values described below as well as determine what value commitments should be adopted.

Respect — We respect life at all stages and promote the dignity and the well-being of every person, which includes:

- Honoring the values and informed choices of our patients, respecting their privacy and confidentiality, and ensuring their safety
- Creating a safe, just and diverse work environment, providing fair wages and benefits, and promoting an appropriate work-life balance
- Protecting the sanctity of human life from conception to natural death. Actions such as

direct abortion, assisted suicide, euthanasia, and embryonic stem cell research are not permitted

Compassion — We reveal the healing and reconciling presence of God through compassionate care focused on the fullness of the person, which includes:

- Accepting patients where they are in their life's journey and embracing them in their totality as persons of mind, body and spirit
- Providing a full range of spiritual and pastoral care services that are integrated with patient care
- Offering comprehensive palliative care and hospice services for patients and their families facing serious, life-limiting illness

Excellence — We provide exceptional care and service through employees and physicians dedicated to our mission, which includes:

- Creating a culture that promotes patient safety and the provision of evidence-based, high-quality care as its number one priority
- Ensuring the organization's integrity in all interactions
- Promoting continuous quality improvement and innovation throughout the organization

Community — We cultivate relationships that inspire service and promote justice in our organization and throughout our communities, with special concern for the poor

and marginalized, which includes:

- Serving uninsured, underinsured, and Medicaid populations within our communities, and considering first, though not exclusively, how significant business decisions impact the poor
- Advocating for a just, sustainable health care system that is accessible and affordable for all
- Assessing unmet community health needs, collaborating with community partners in addressing these needs and maintaining a robust community benefit program that allows us to track progress and report results to key constituents

Stewardship — We care for the environment and use our financial, human and natural resources responsibly, which includes:

- Pursuing practices and programs that promote environmental sustainability in our operations
- Developing the skills and talents of our employees and physicians through a commitment to personal and professional development
- Ensuring the long-term financial viability of our ministry through sound business practices and socially responsible investing

Ethical guidelines for new business arrangements with other-than-Catholic parties

Prior to a definitive agreement being signed in any new business arrangement involving an other-than-Catholic party, CHCO needs to identify if any cooperation issues will arise as a result of the prospective partner engaging in certain medical interventions with ERD restrictions. The restrictions that may materialize are outlined below for the major type of business arrangements and are segmented into three sub-categories, namely: (1) “prohibited” services, which are not allowed under the arrangement and are not subject to carve-out; (2) “tolerable” services, which

may be provided but are done so without the approval or support of CHCO; and (3) “carve-out” services, which may be provided if established by the other-than-Catholic party and the cooperation guidelines are met. Senior leaders from strategy and other areas should use the information below for discussion purposes when considering a new business arrangement. However, a formal analysis addressing cooperation issues should be completed by a qualified and experienced ethicist before a definitive agreement is signed.

Business arrangement		Medical interventions with ERD restrictions			Cooperation guidelines
		Prohibited	Tolerable	Carve out	
Health system or hospital Applies equally to joint operating agreements wherein CHCO has a controlling interest	Sole or majority control	<ul style="list-style-type: none"> ■ Direct abortion ■ Euthanasia and assisted suicide ■ In vitro fertilization ■ Embryonic stem cell research 	NA	<ul style="list-style-type: none"> ■ Direct contraception ■ Direct sterilization 	None of the prohibited or carve-out medical interventions can be provided because CHCO is the sole or majority owner and cannot legitimately distance itself morally from the wrongdoing. However, the former owner or a new, non-CHCO entity (e.g. community foundation) may choose to arrange for and provide the carve-out medical interventions in non-CHCO majority-controlled and/or identified spaces/buildings with no CHCO involvement.
	Minority control	<ul style="list-style-type: none"> ■ Direct abortion ■ Euthanasia and assisted suicide ■ IVF ■ ESCR 	NA	<ul style="list-style-type: none"> ■ Direct contraception ■ Direct sterilization 	The carve-out medical interventions may be provided in the hospital if the following conditions are met: Governance: CHCO must have no more than a minority of board seats and CHCO board members must recuse themselves from decisions pertaining to the carve-out medical interventions. Finance: CHCO must not derive any revenue/profit from or provide direct funding for the provision of the carve-out medical interventions. Management: CHCO must not oversee the management of the carve-out medical interventions. Such medical interventions should be managed by non-CHCO physicians and/or employees who report to a subset of the board that does not include CHCO members. Performance: CHCO employees and physicians must not provide the carve-out medical interventions as part of their employment agreement; the carve-out medical interventions must not be provided in CHCO majority owned and/or identified spaces/buildings; and CHCO's name should not be associated with the hospital if at all possible to avoid scandal.
	Management	<ul style="list-style-type: none"> ■ Direct abortion ■ Euthanasia and assisted suicide ■ IVF ■ ESCR 	NA	<ul style="list-style-type: none"> ■ Direct contraception ■ Direct sterilization 	Typically, hospital affiliation arrangements do not require any carve-outs because of the limited involvement of CHCO. However, if the affiliation agreement involves CHCO in the areas of governance, finance, management and/or the provision of tolerable medical interventions, the carve-out guidelines listed above would apply as appropriate.
	Affiliation	<ul style="list-style-type: none"> ■ Direct abortion ■ Euthanasia and assisted suicide ■ IVF ■ ESCR 	<ul style="list-style-type: none"> ■ Direct contraception ■ Direct sterilization 	NA	Though CHCO neither condones, approves of, nor supports counseling and medical interventions related to contraception and sterilization, these interventions, provided by CHCO physicians in outpatient settings, may be tolerated under the concept of professional moral agency and non-interference in the patient/physician relationship when deemed necessary by the physician due to medical indications and in consultation with the patient. As with other medical interventions, CHCO physicians are required to document in the patient's chart that services or procedures related to contraception or sterilization are medically indicated. Of note, CHCO physicians are prohibited from marketing or advertising medical interventions related to contraception and sterilization. Additionally, print and other educational materials related to contraception and sterilization should not be displayed publicly. Employment agreements with CHCO physicians who, in order to provide the standard of care to their patients, deem it necessary to continue to provide medical interventions that are prohibited in CHCO
Physician practice Encompasses all types of employment agreements with physicians, including professional service agreements, at any CHCO outpatient care site		<ul style="list-style-type: none"> ■ Direct abortion ■ Euthanasia and assisted suicide ■ IVF ■ ESCR 	<ul style="list-style-type: none"> ■ Direct contraception ■ Direct sterilization 	NA	

Continued on next page



Business arrangement	Medical interventions with ERD restrictions			Cooperation guidelines
	Prohibited	Tolerable	Carve out	
<p>Physician practice</p> <p><i>Continued from previous page.</i></p>				<p>hospital inpatient settings (e.g., direct sterilization), excluding those that involve the direct taking of life, should be structured as follows:</p> <p><u>Less than 100% employment</u> (e.g., 97.5% CHCO employment with 2.5% limited private practice capacity) with right of limited private practice capacity to provide inpatient prohibited medical interventions (excluding those that involve the direct taking of life) only at non-CHCO facilities. Insurance coverage provided by CHCO to such physicians may remain in effect and support services (e.g., scheduling, billing) may continue to be provided. Payments for medical interventions covered under these terms should be directed to the individual physician and not to the CHCO.</p>
<p>Health plan</p>	<ul style="list-style-type: none"> ■ Euthanasia and assisted suicide 	<ul style="list-style-type: none"> ■ Direct contraception ■ Direct sterilization 	<ul style="list-style-type: none"> ■ Direct abortion ■ IVF 	<p>Member benefits related to contraception and sterilization may be covered by a CHCO-owned Health Plan or within a CHCO risk-based contract. Though CHCO neither condones, approves of, nor supports these benefits, the coverage of such benefits may be tolerated for two reasons, namely: (1) they are benefits for which coverage is required under federal law as part of the Patient Protection and Affordable Care Act; and (2) medical interventions related to contraception and sterilization are ethically permissible in limited circumstances within Catholic teaching making it unreasonable for health plans to absolutely exclude them as covered benefits and impossible for health plans to relegate coverage to only permissible circumstances without inappropriately intruding into the patient/physician relationship and usurping clinical decision-making authority. To avoid the possibility of scandal, however, CHCO should consider inserting a disclaimer into its health plan contracts and Summary Plan Descriptions that reads similarly to the following:</p> <p style="padding-left: 40px;">“Any benefits covered by this plan that are related to contraception and sterilization are provided solely and exclusively by reason of legal requirement. Contraception and sterilization are contrary to Catholic moral teaching. CHCO does not approve, condone, or promote contraception or sterilization.”</p> <p>If benefits for direct abortion and/or IVF are required to be covered under federal and/or state law, they should be carved-out and structured as follows to create maximum moral distance for CHCO:</p> <ol style="list-style-type: none"> 1. A separate insurer with its own license is enlisted to make decisions related to, accept payment for, assume risk for, contract with providers, and oversee the administration of the carve-out benefits. 2. A separate policy is established from that of the CHCO-owned Health Plan for the legally required carve-out benefits. 3. A note indicating the carve-out benefits are excluded within the CHCO-owned Health Plan product is added to informational materials, including Summary Plan Description, and the separate insurer develops its own information materials and sends them directly to the members without CHCO involvement.
<p>Pharmacy Benefit Management (PBM)</p>	<ul style="list-style-type: none"> ■ Abortifacient medications (i.e., RU486) ■ Medications used solely for purposes of euthanasia or assisted suicide 	<ul style="list-style-type: none"> ■ Contraceptive medications 	<p>NA</p>	<p>Member benefits related to contraceptive medications may be managed by a CHCO-owned PBM. Though CHCO neither condones, approves of, nor supports these benefits, the management of such benefits may be tolerated for two reasons, namely: (1) they are benefits for which coverage is required under federal law as part of the Patient Protection and Affordable Care Act; and (2) contraceptive medications are ethically permissible in limited circumstances within Catholic teaching, making it unreasonable for PBMs to absolutely exclude them as managed covered benefits and impossible for PBMs to relegate management to only permissible circumstances without inappropriately intruding into the patient/physician relationship.</p>

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Business arrangement	Medical interventions with ERD restrictions			Cooperation guidelines
	Prohibited	Tolerable	Carve out	
Pharmacy Benefit Management (PBM) <i>Continued from previous page.</i>				<p>ship and usurping clinical decision-making authority. To avoid the possibility of scandal, however, CHCO should consider inserting a disclaimer into its PBM contracts and Summary Plan Descriptions that reads similarly to the following:</p> <p>"Any benefits managed under this plan that are related to contraception are provided solely and exclusively by reason of legal requirement. Contraception is contrary to Catholic moral teaching. CHCO does not approve, condone, or promote contraception or contraceptive practices."</p>
Clinical Integrated Organization (CIO) or Accountable Care Organization (ACO)	Services prohibited for all providers <ul style="list-style-type: none"> ■ Direct abortion ■ Euthanasia and assisted suicide ■ ESCR 	Other services prohibited for CHCO providers Inpatient <ul style="list-style-type: none"> ■ Direct contraception ■ Direct sterilization ■ IVF Outpatient <ul style="list-style-type: none"> ■ IVF 	Other services prohibited for non-CHCO providers NA	<p>CHCO may arrange for, structure, and be the sole owner of CIO and ACO arrangements that involve non-CHCO providers who provide medical interventions that are prohibited for CHCO providers, excluding those that involve the direct taking of life, if the following conditions are met:</p> <p>Governance: Non-CHCO providers must have at least a minority of board seats, and CHCO board members must recuse themselves from decisions pertaining to medical interventions prohibited for CHCO providers.</p> <p>Finance: CHCO must not derive any direct revenue/profit from or provide direct funding for the provision of medical interventions prohibited for CHCO providers.</p> <p>Management: CHCO must not oversee the management of medical interventions prohibited for CHCO providers. Such medical interventions should be managed by non-CHCO providers who report to a subset of the board that does not include CHCO members.</p> <p>Performance: CHCO providers must not participate in or provide essential support to non-CHCO providers for the provision of medical interventions prohibited for CHCO providers; and the medical interventions prohibited for CHCO providers must not be provided in CHCO majority-controlled and/or identified spaces/buildings.</p>

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APPENDIX 4

Mission/ethics integration plan checklist

Before the definitive agreement is signed, the CHCO's system mission and ethics staff should conduct an on-site assessment (if applicable) and document review of the prospective partner to determine key integration opportunities based on the list of items detailed below. Note that some items pertain to all new business arrangements, whereas others are specific to a certain type of arrangement. At the completion of this process, System mission and ethics staff should have a well-developed integration plan that clearly outlines the key mission and ethics components that will need to be developed as well as a timeline, communication plan, and a list of responsible parties that corresponds to each action item of the plan.

All Arrangements

A. When applicable to the particular arrangement, meet with board members and senior leaders from the prospective partner to discuss the organization's:

- History and vision, mission and values
- Approach to charity care and financial assistance for uninsured and underinsured patients
- Past three years of community benefit data
- Compensation philosophy and level of employee benefits
- Standing in the community and with the local diocese
- Past and current advocacy initiatives
- Compliance history and environmental record

B. When applicable to the particular arrangement, determine if the prospective partner will formally adopt CHCO's vision, mission, and values. If the decision is "yes," then a process for implementation and a time frame should be set for adoption and clearly communicated among the parties. Note, this is different from the prospective partner committing to CHCO's value commitments in Phase 1 — here the question is whether CHCO's vision, mission, and values will replace those of the prospective partner.

C. When applicable to the particular arrangement, establish a plan for developing and integrating the following:

- Board member and senior leader formation
- Ethics education for caregivers and senior leaders
- Education around CHCO's vision, mission and values
- Mission awareness teams
- Prayer at the beginning of meetings
- Mission days
- Foundress Day and Heritage Week

D. When applicable to the particular arrangement, review policies, procedures and forms related to the items listed below. Plans should be prepared to ensure the prospective partner's policies conform, as appropriate to the business arrangement, with corresponding CHCO policies post-closing.

- Abortion and maternal-fetal care
- Advance directives

- Advertising and marketing practices
- Affirmative action and diversity in hiring
- Allocating health care resources
- Artificial nutrition and hydration
- Assisted reproductive technologies
- Billing and collecting patient liabilities
- Brain death and the determination of death
- Care of critically ill newborns
- Care of persons with infectious diseases (including HIV/AIDS)
- Charity care and financial assistance
- Code of conduct and ethics
- Community benefit and healthy communities
- Confidentiality
- Conflicts of interest and professional responsibilities
- Contraception and sterilization
- Disclosure of medical error
- Disposal of hazardous waste
- Do-not-resuscitate orders
- Downsizing or reduction in force (RIF)
- Ectopic pregnancy
- Emergency preparedness
- Employee conscientious objection
- Employment non-discrimination
- Executive compensation
- Euthanasia and physician-assisted suicide
- Fetal demise and disposition
- Genetic testing and counseling
- Informed consent
- Medical futility
- Newborn screening
- Organ donation, including donation after cardiac death
- Organizational decision-making process
- Palliative care and pain management (including palliative sedation)
- Patient rights and responsibilities
- Prenatal testing and counseling
- Preoperative pregnancy testing
- Role of minors in clinical decision making
- Selection of vendors
- Sexual harassment
- Socially responsible investing
- Surrogate decision making
- Treatment of female victims of sexual assault
- Triage and utilization of specialty units
- Welcoming policies to LGBT patients and visitors
- Withholding and withdrawing life-sustaining treatment

Continued on next page

Mission/ethics integration plan checklist

Hospital Arrangements

A. When applicable to the particular arrangement, meet with the Ethics Committee (EC) chairperson and review EC policies and related materials (e.g., EC member training program, EC evaluation process, EC member self-evaluation tool, EC development planning document, EC brochure, EC customer feedback survey, ethics consultation protocol, ethics consultation request form, ethics consultation tracker form, etc.). If the prospective partner does not have an EC, plans should be prepared to develop one post-closing according to CHCO guidelines.

B. When applicable to the particular arrangement, meet with the Institutional Review Board (IRB) chairperson and review IRB policies and related materials (e.g., IRB member training program, IRB member guidelines, research protocol review checklist or process). If the prospective partner is engaged in or plans to conduct research involving human subjects and does not have an IRB, plans should be prepared to develop one post-closing according to CHCO guidelines.

C. When applicable to the particular arrangement, meet with the palliative care coordinator and review palliative care policies and related materials (e.g., marketing materials, clinical quality and other data related to palliative care metrics, patient/family satisfaction data). If the prospective partner does not have a palliative care program, plans should be prepared to develop one post-closing according to CHCO guidelines.

D. When applicable to the particular arrangement, meet with the pastoral care director (or equivalent) and review pastoral care policies and related materials. If the prospec-

tive partner does not have a pastoral care program, plans should be prepared to develop one post-closing according to CHCO guidelines.

E. When applicable to the particular arrangement, review the prospective partner's most recent Community Health Needs Assessment (CHNA). If the prospective partner does not have a CHNA and is required to under law, plans should be prepared to complete one post-closing according to CHCO guidelines.

F. When applicable to the particular arrangement, establish and educate relevant personnel on procedural guidelines for addressing requests for inpatient female sterilization procedures.

G. When applicable to the particular arrangement, establish a plan for developing and integrating the following:

- Sacramental services
- Diocesan-approved chapel

Physician Practice Arrangements

A. When applicable to the particular arrangement, meet with senior leaders to discuss current initiatives and future needs around ethics consultation, physician ethics education, pastoral and palliative care services to patients, and community benefit.

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