

FORMING A WELLNESS COALITION

The Creators of a Successful Program for Priests in the Milwaukee Archdiocese Plan to Expand It to Include Others

What do all six of the Catholic health care systems in the Archdiocese of Milwaukee have in common? The answer is not location. The geographic area served by the archdiocese spans southeastern Wisconsin, starting at Lake Michigan and reaching west to Waukesha and including Kenosha, Racine, Milwaukee, Sheboygan, and Fond du Lac. Nor is sponsorship what the systems share. The Wheaton Franciscans, Felician Sisters, Daughters of Charity, Sisters of St. Agnes, and Hospital Sisters of St. Francis all play a part in delivering health care in the region.* In some cases, the systems sponsored by these congregations are in direct competition with one another. But all have a common need coupled with a common mission: Taking care of the region's priests.

In the archdiocese, as in many other dioceses around the country, the number of active priests is rapidly declining. The average age of archdiocesan priests is 60. And the number of priests reaching or nearing the typical retirement age of 68 is growing at the same time that the availability of new candidates to the priesthood is shrinking. In June 2003, two new priests were ordained for the archdiocese. That year eight priests retired and several more died. The imbalance has reached a critical point.

Because the majority of parish priests are in their 50s and 60s, their health is paramount. The typical priest works as hard as a corporate execu-

tive, putting in 50 and 60 or more hours a week. In addition, priests work six or seven days a week, including evening meetings on most days. Many priests serve two or even three parishes, because there are not enough of them to go around. Added to the time pressures are the more personal pressures of dealing with the wide range of human needs, social and spiritual, a life of service for which they entered the priesthood in the first place. Ministering to the "flock" can be both immensely rewarding and emotionally draining at the same time. There is constant demand on a priest's time.

The archdiocese's leaders, especially the recently retired Archbishop Rembert Weakland and Fr. Joseph Hornacek, the archdiocese's vicar for priests, recognized an urgent need to try to keep its priests healthy. This has continued to be a priority under the archdiocese's current leaders, Archbishop Timothy Dolan and Auxiliary Bishop Richard Sklba. They know that health has different components: body, mind, and spirit, which interact with and influence each other. Their vision has been to create a wellness program for priests and to partner with Catholic health care systems to provide health education services for them. This is where the idea for a collaborative initiative began.

Those of us who were involved in developing an overall plan applied to it the University of Wisconsin-Extension's "evaluation logic model" for collaboration. The model, intended for use in program planning, implementation, evaluation, and communication, has six components:

- **Situation** The problem or issue that the program is to address sits within a setting or situation for which priorities are set.

- **Inputs** The resources, contributions, and investments made in response to the situation lead to

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*U.S. Province of the International Congregation of the Franciscan Sisters, Daughters of the Sacred Hearts of Jesus and Mary, Wheaton, IL; Congregation of the Sisters of St. Felix, Chicago; Daughters of Charity of St. Vincent de Paul, St. Louis; Congregation of the Sisters of St. Agnes, Fond du Lac, WI; and the Hospital Sisters of St. Francis, Springfield IL.

- *Outputs* The activities, services, events, and products that reach people and users. Outputs lead to

- *Outcomes* The results or changes for individuals, groups, agencies, communities, and/or systems.

- *Assumptions* The beliefs we have about the program, the people, the environment, and the way we think the program will work

- *External Factors*

The environment in which the program exists includes a variety of external factors that interact with and influence the program action.¹

The model gave us a useful framework for creating a collaborative that could address both the immediate and future needs of the initiative.

SITUATION

In 2001 the archdiocese's Priests' Wellness Council formally asked the six Catholic health care systems to develop a priests' wellness program. The presidents of those systems saw that the collaboration needed to make the program work would, besides improving priests' health, also increase the visibility of Catholic health care in the communities the systems served.

When those of us who were the systems' representatives met to discuss the proposed program, we saw that it must cover a large geographic area. Fortunately, each of the archdiocese's larger cities has a Catholic health system or hospital in its area. We saw that, by linking them all together, we could cover the entire archdiocese.

In addition to the geographic advantage, we recognized some natural linkages. Although sponsored by different religious communities, all our organizations share the same mission: to provide—in the spirit of our founders and emulating the healing ministry of Jesus and the church—health care and preventive services to the communities we serve. Although the wording may vary from one mission statement to the next, none of us questions what we are about. Central to carrying out our mission is adhering to the *Ethical and Religious Directives for Catholic Health Care Services*. We also share the desire to serve those in our communities with the greatest need.

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Sometimes that need is economic; sometimes it is illness-based. In this case, we identified a need to care for our caregivers.

THE INPUTS

To carry out our project, we formed the Catholic Healthcare Collaborative (CHC), a team composed of representatives from each of the six partner organizations. Critical to the team's effectiveness was the inclusion of

decision makers from each organization. This meant that senior administrators were required to devote a significant amount of time to planning the program. The team of 12 or so was composed of people from different fields—mission, nursing, business development, marketing, and other areas—so that it might benefit from a variety of perspectives. The team thus not only crafted the elements of a wellness program but also modeled collaboration. This was the beginning of strong, positive relationships that continue to be productive today. Enhanced respect and trust have been fostered as we continue to develop our program.

In addition to contributing leaders' time and talents, all participating health systems agreed to contribute the financial resources necessary to implement the program. It was decided that the percentage contributed by each system would vary according to the percentage of the archdiocese's priests in that system's geographic area. This prorated approach is also consistent with the size of each organization. The two largest systems, Columbia-St. Mary's and Covenant Healthcare, both based in Milwaukee, have the largest number of priests in their areas: about 100 apiece.

Critical to the quality of the programming was physician input. The priests' wellness program benefits from the input of Carmelo Gaudio, who chairs the Priests' Wellness Council, as well as physicians from each of our systems. These are James Ketterhagen, MD, of Columbia-St. Mary's, the program's medical director; Gene McMahon, MD, of Covenant Healthcare; James Concannon, MD, of United Hospital System, a Wheaton Franciscan-sponsored system; Kirk Veit, MD, and David Weber, MD, both from Agnesian

Healthcare, sponsored by the Sisters of St. Agnes; and James Kuplic, MD, from St. Nicholas Hospital, a member of the Hospital Sisters Health System.

These physicians and others participate in the program's physician advisory council, which meets at least once a year. As council members, the doctors provide advice on medical standards as they apply to the wellness

program. In addition, they review data on participation and outcomes, including such clinical measures as cholesterol level, body mass index, and blood pressure. Individual data is confidential, of course. But we can, by monitoring changes among the archdiocesan priests, make assumptions about the efficacy of the priests' wellness program.

The CHC also has an Administrative Oversight Council, made up of executives from each of the systems, which provides administrative support for the program. This group's role is to oversee the program's implementation. Because council members have senior roles within their systems and direct access to the CEOs, they can make decisions efficiently. The group meets quarterly to go over the program's budget and activities and to offer advice on direction, enhancements, and other matters.

The frontline inputs are the most visible. These come from the program coordinator and the people we call "nurse advocates." When enrolling in the program, a priest signs a release-of-information form and designates one of the six participating systems as his wellness site. Each site has a registered nurse—a nurse advocate—whose job it is to assist priests in developing personalized wellness plans for themselves. The wellness site does not replace the priest's usual health care access points; he continues to receive care from his personal physician and the hospital where that physician admits patients. However, the nurse advocate does share screening test results and other pertinent information with the priest's permission. This coordination of care can be critical.

Last year, we had a poignant example of this fact. A priest in his early 60s, still active in parish

A "nurse advocate"

helps the priest

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ministry, had his blood drawn at a wellness event. His prostate specific antigen (PSA) test, which screens for prostate cancer, had results that were unexpectedly very high. And, indeed, the priest and his physician soon learned that he had prostate cancer. The surgery and treatment went well, and, because he benefited from early detection, the priest expects a full recovery. He believes that the

wellness program saved his life.

We encourage priests to view their nurse advocates as wellness coaches and liaisons. The nurse advocate is available for one-on-one counseling concerning nutrition and exercise, cholesterol management, blood pressure control, and a wide variety of other health issues; he or she also serves as a sounding board in discussions of daily stressors. When indicated, the nurse advocate can also make referrals to mental health professionals.

THE OUTPUTS

In addition to its one-on-one wellness coaching, the program has elements that serve the priest population as a whole. The largest of these is the annual October wellness event. A full day is set aside for priests from throughout the archdiocese to come together at the Archbishop Cousins Catholic Center in Milwaukee for a day of education and testing.

In anticipation of this event, we send a packet of materials to each archdiocesan priest, both those active and those retired, as well as to religious order priests who serve in archdiocesan parishes. Even those who have not participated in the past are invited to attend to submit data to our database. It is our hope that simple exposure to the materials will itself influence better self-care. The packet contains information about the schedule of events, workshops and speakers, tests, and educational displays.

The packet also gives directions to the locations of free blood tests and a release-of-information form that enables the priest's nurse advocate to receive the results and share them with his physician. The packet also contains a health risk assessment and a health behavior questionnaire that asks

if there has been improvement in such specific areas of wellness as nutrition, exercise, smoking abstinence, moderation in alcohol use, and stress management. The questionnaire has a section in which participants can list various accomplishments, such as weight loss, blood pressure reduction, or other behaviors leading to positive results. These surveys provide a rich resource that we use in measuring the impact of our wellness strategies beyond clinical improvements.

As a follow-up to this annual wellness event, each priest is encouraged to schedule an appointment with one of the nurse advocates to go over test results and map out a personal wellness plan using the risk assessment's results and information. With this very individualized model, the priest can tailor appropriate goals and activities. About 30 percent of the event's participants have developed a wellness plan. Many of the problems listed are those common among the general population: obesity, hypertension, hypercholesterolemia, and lack of exercise. However, our program's population has, in addition, a stress level that has increased between the program's first and second years by 13 percent. We attribute the rising stress level to a number of factors: a dwindling number of priests combined with an increasing workload; increasing isolation caused by increased administrative duties and a diminishing amount of time for the more personal ministerial functions; the current sexual-abuse crisis, which has produced a climate of mistrust concerning priests; and the increasing complexity of administrative functions.

To help respond to this increase in self-reported stress, we have offered workshops facilitated by psychologists and other professionals trained in behavioral health. Didactic workshops have focused on the development of new perspectives and tools to deal with stress. Interactive workshops have provided a confidential forum in which priests can share their feelings and concerns with professional facilitation. In October 2003, the annual wellness event offered workshops dealing with such issues as loneliness, morale, spiritual wellness, and self-esteem; another workshop demonstrated relaxation techniques.

A feature of the program that we intend to increase over the next year is outreach and local programming. The archdiocese is divided into 16 geographic districts. The priests in these districts, clustered near one of the participating health systems, regularly come together for district meetings. By offering workshops either at the district meeting or at the local health system, we hope to

reach not only the active participants in the wellness program, but some of the non-participants as well. We also may use small interventions, such as blood pressure checks, as an entrée to communication. We will use data from the questionnaires and evaluations of the event to determine areas of greatest interest and need.

Since exercise is both an important need and a benefit to wellness, we have been working on ways to increase exercise among priests. Workshops have been conducted on walking, yoga, and other forms of exercise. This year, we provided pedometers at no cost to encourage awareness of the benefits of walking 10,000 steps a day and to engage priests in this practice. The pedometer will provide an easy way to measure progress and create a sense of accomplishment and further motivation. In addition, the participating health systems are allowing priests to use their exercise or rehabilitation facilities to engage in regular exercise.

These program elements are communicated on a regular basis to all priests in the archdiocese through our newsletter, *The Wellness Advocate*. Produced several times a year, the newsletter is written specifically for priests and provides education and updates on wellness issues and summarizes new research findings that have relevance for the program's population.

THE OUTCOMES

Documenting results can be challenging for wellness programs. Improving wellness is very different from treating acute illness. The results are often less visible, less dramatic, and take longer to achieve. For example, a patient with an ear infection has symptoms (pain), sees a doctor, and gets a prescription for an antibiotic. Typically, he feels better within the week. The impact on the patient is dramatic; he no longer has pain and his life returns to normal. He is cured.

Consider, on the other hand, a hypothetical person who is 30 pounds overweight, has elevated cholesterol, and mildly elevated blood pressure. He is stressed from overwork and doesn't find time to exercise. He eats fast food and snacks because he doesn't have time to cook. (Priests don't have spouses to do the cooking; few have housekeepers or cooks.) Although this person has no complaints, he may well be at increased risk of developing heart disease, a stroke, diabetes, or depression. But because he has no symptoms, he is not motivated to see a physician. While he may sense vaguely that he ought to improve his wellness, he is unlikely to make it a priority.

If, on the other hand, this person were to par-

ticipate actively in a wellness program, he would very likely try to improve his nutrition, increase his exercise, and deal effectively with his stress level. His goals might include losing weight, improving exercise tolerance, and feeling less stressed. If successful in these efforts, he will probably reduce his cholesterol and blood pressure and thereby avoid having a stroke, heart attack, or diabetes.

These are significant outcomes—but hard to measure. You cannot count the absence of an event such as a heart attack as an outcome. There is no proof that the person would have developed heart disease or diabetes without changing his lifestyle. We *can* measure cholesterol and blood pressure and note reductions, which are positive. Weight reduction can also be documented, though it may take a longer period of time to achieve.

Measuring the positive results of a wellness program requires patience. In fact, documenting improvements over time in the entire population of program participants may provide the best evidence of positive outcomes. The CHC wellness program is doing just this sort of measurement. We have found, for example, that nearly 50 percent of priests who have cholesterol measurements for more than one year demonstrate reduced cholesterol.

Self-reported change in health behavior is another means of measuring outcomes. Each year we send to our participating priests a brief questionnaire called “How Are You Doing?” The questionnaire allows participants to document positive change in nutrition, exercise, weight loss, blood pressure control, and stress management. It also gives space for comments, so respondents can report other ways in which they have improved their health and wellness. This self-reported data is a rich source of outcomes. Between October 2001 and October 2002, 118 respondents submitted questionnaires documenting wellness changes. Improvements were reported in these categories:

- Nutrition and eating habits (43 percent of respondents)
- Physical activity (42 percent)
- Weight management (29 percent)
- Coping with stress (28 percent)
- Moderation in alcohol consumption (24 percent)
- Living an overall healthy lifestyle (43 percent)
- Weight loss (28 percent)
- Cholesterol reduction (24 percent)
- Blood pressure reduction (25 percent)
- Smoking cessation (3 percent)

The benefits evidenced by this admittedly anecdotal feedback are impressive. Many of the priests have expressed an appreciation of the fact that their well-being is a priority for the archdiocese and for the health care systems involved. Awareness is an important first step in developing wellness, and priests have reported that “the wellness message is out there.” The CHC strives to empower people to take care of themselves.

Participation rates and satisfaction surveys are important outcome measures. Nearly 50 percent of the eligible population has at some time participated in at least one aspect of the wellness program. However, we need to continually reach out to those priests who do not yet participate, because they may need health improvement more than those who do. Because the program is voluntary and offers no financial incentives, reaching nonparticipants is an even greater challenge.

Satisfaction surveys and evaluations of programs have been consistently high. More than 90 percent of respondents have described themselves as “very satisfied.” The CHC pays close attention to this feedback and uses it to enhance the program.

ASSUMPTIONS

In order to make our wellness program effective, we needed to draw up assumptions concerning the program’s population, its environment, and the participating health systems. Toward this end, we used data taken from a survey that asked all priests in the archdiocese about their health, lifestyles, and concerns. We know, for example, that the average age of our priest population increases each year, resulting in increased health risks. Additional characteristics of this population include the following:

- Priests are male. Research shows that men are not as likely as women to access the health care system; nor are they likely to do it as frequently.
- Priests are single. The absence of a spouse willing and able to monitor a priest’s health status and encourage healthy behaviors may lead to reduced wellness.
- Many priests live alone. The fact that they perform routine activities of daily living (cooking and cleaning, for example) alone and have limited social interaction may negatively affect wellness.
- Priests have a greater need than other people for privacy and confidentiality, to protect parishioners’ interests.
- Priests have more demands on their time than most other people.

Recognizing priests’ need for privacy and confidentiality, the CHC works hard to establish trust-

ing relationships among them, the program coordinator, and nurse advocates. Recognizing their need to use time wisely, it seeks to establish clear, concise communications with them and to schedule workshops and other health care events at venues close to them and at hours convenient for them. We have found that doing these things is essential if we want their participation.

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employees. We draw upon professionals from among the member organizations to lead our workshops and other educational presentations.

The limits on our resources will make expansion a challenge. We are exploring the possibility of obtaining grants to finance some of this work. In the meantime, we are taking "baby steps" and using resources in the most efficient way possible.

EXTERNAL FACTORS

The environment has been a critical feature in the development of the CHC and its wellness program. The competitive nature of the health care market is both a challenge and an opportunity. In this case, the CHC is competing with health care systems that have significant resources to provide programming. However, one of our goals is enhancing the visibility of Catholic health care in the communities we serve. By coming together to create a collaborative, we cover a region too large to be served by a single system. In communities in which more than one CHC partner has a presence, we have agreed to avoid competition in meeting the goals of our program.

Recently the CHC has been exploring ways to expand its work. Our collaboration with each other has led us to consider collaborating with other partners, such as Catholic Charities. Our goal is to avoid duplication of services and reap the benefits of economies of scale. It is our hope that we can work in concert with each other on similar issues. We also are exploring ways in which the significant contributions of parish nurses can be a springboard for wellness programming. We are looking at increasing our target populations to include women religious, parish and school employees and volunteers, and the Catholic community in general.

LESSONS LEARNED

Time and resources are our challenges. Because the CHC's work is mission-based, it has no revenue to offset expenses. Both its financial and human resources are limited. The collaborative's single full-time employee plans and implements its activities. Our nurse advocates are part-time

employees. One strategy toward this end is "training the trainer," using our expertise to create wellness education that can be replicated by those whom we educate. We are also well-positioned to act as a clearinghouse, providing information about available classes, professional assistance, and other resources within our systems.

We have learned that the keys to collaboration are communication and participation. Whenever we make a decision for the CHC, we try to have everyone represented at the table. Member systems are free to decide whether they will participate in a particular program. Therefore, it is essential that we have full participation in decision making and agreement on strategy as we continuously improve our work. Sometimes we have to revisit our goals: mission, visibility, and perception, and enhancing the wellness of populations. By modeling our collaboration, we enhance our product.

In the more than two years that the CHC's members have been working together, we have seen our unity strengthened. Relationships have been built across corporate lines, with other organizations, and with the archdiocese. Trust has increased, and our commonality as representatives of Catholic health care has become more apparent. It is our hope that this collaboration will continue to grow and function well for a very long time. □

NOTE

1. Evaluation Logic Model, Division of Cooperative Extension, University of Wisconsin-Extension, Madison, WI, available at www.uwex.edu/ces/pdande/evaluation/evallogicmodel.html.