Is Catholic Health Care Assessing Spirituality?

BILL BRINKMANN

One of my favorite images for the healing ministry is the parable of the fig tree (Luke 13:6-9). In the story, a disappointed owner wants to cut down a fig tree that is not producing fruit. His gardener suggests giving the tree extra cultivation and fertilizer, then reassessing its productivity.

The parable represents several truths about our ministry. First, there is a need to assess whether our work is producing the intended fruit. In the story, the owner's assessment is so decisive that he is willing to destroy the tree and start over. Also, the story suggests the need to make changes (cultivate the ground in which the ministry is planted) and fertilize (reinvigorate the ministry) in order to provide the intended bounty. When Jesus gave us the parable of the fig tree, he may have had another verse in mind: "The fruit of a tree shows the care it has had" (Sirach 27:6).

Catholic health care's mission is the ever-emerging fulfillment of Jesus' healing ministry. We are continuously evolving. In that context, I believe it is essential for Catholic health care to systematically, and with humility, ask ourselves how well we are doing at moving toward that fulfillment. Are we producing the intended fruit?

How can we measure our progress in the healing component of the reign of God? This is both a technical and a spiritual question. Technically, it requires that we clearly identify those organizational behaviors and measurable phenomena that we associate with the principles of Catholic health care. Spiritually, it requires an examination of our motives, the willingness to innovate in the service of others and the humility to accept our flaws.

Over the past decade, some systems have put processes into place to explore how well their daily operations implement the principles of Catholic health care. At the University of St. Thomas in St. Paul, Minnesota, the Veritas Institute has collaborated with some of these ministries to develop a systematic approach to ministerial assessment, based on the Malcolm Baldrige philosophy of total quality management and continuous process improvement. More recently, the Catholic Health Association has formed a committee to codify the lessons learned from Catholic health care systems' ministerial identity assessment activities and to develop a framework of proven practices for such assessments. CHA anticipates publishing a document in mid-2018 that describes the framework.

Catholic health care has continued to implement formation programs to assist leaders and caregivers in learning and then living the ministry's principles. I believe that whether they were developed in-house or in collaboration with Catholic educational institutions, these formation programs have had a profound effect on how the ministries are assessing themselves.

An old adage says that where you stand determines what you see. The owner of the fig tree saw a lack of productivity, while the gardener saw a need to nourish. So, too, my perspective has been affected by where I have stood. After a 30-year career in the U.S. Navy, where mission readiness

was a constant concern, I used a master's degree in health care mission from Aquinas Institute of Theology, St. Louis, as a bridge into the ministry. Working first in a medium-sized Catholic system doing leadership formation for three years led to serving in a large system for eight years, with responsibility for leadership formation, ministerial assessment and patient experience. I also have found serving on CHA committees for leadership formation and for Catholic ministerial assessments to be formative.

Since 2011, I have been working with the Veritas Institute to assist leaders in assessing their ministries. It has been my pleasure to participate in more than 50 such assessments. I also have continued to work with Aquinas Institute in developing and delivering leadership formation programs.

Throughout these formation and assessment activities, I have found CHA's "Shared Statement of Identity for the Catholic Health Ministry" very useful. It is derivative of the *Ethical and Religious Directives for Catholic Health Care Services* and presents those principles in simple, accessible language. The Shared Statement's wording is memorable and inspirational, and it identifies the ministry's fundamental commitments. If there were one document that I would want a new employee or associate in Catholic health care to assimilate, it would be the Shared Statement. It aligns very well with the principles exhibited in the founding stories of our many institutions, and it provides an outline for our formation and assessment efforts.

The Shared Statement is a useful tool in characterizing our strengths and opportunities for improvement as generally identified in the ministry assessments to date. Before we review our perceived strengths and opportunities, let me say that these observations are not directed at specific health care systems or facilities. They represent my perspective on the healing ministry at large, based on many assessments and formation experiences with multiple large and small ministries, in urban and rural settings. They are impressions, based on my experiences.

STRENGTHS

The People: The most prominent positive characteristic of Catholic health care, in my view, is the quality of the people it attracts. In general,

A Shared Statement of Identity for the Catholic Health Ministry

We are the people of Catholic health care, a ministry of the church continuing Jesus' mission of love and healing today. As provider, employer, advocate, citizen — bringing together people of diverse faiths and backgrounds — our ministry is an enduring sign of health care rooted in our belief that every person is a treasure, every life a sacred gift, every human being a unity of body, mind and spirit.

We work to bring alive the Gospel vision of justice and peace. We answer God's call to foster healing, act with compassion, and promote wellness for all persons and communities, with special attention to our neighbors who are poor, underserved and most vulnerable. By our service, we strive to transform hurt into hope.

AS THE CHURCH'S MINISTRY OF HEALTH CARE, WE COMMIT TO:

- Promote and Defend Human Dignity
- Attend to the Whole Person
- Care for Poor and Vulnerable Persons
- Promote the Common Good
- Act on Behalf of Justice
- Steward Resources
- Act in Communion with the Church

they seem committed to their institutions' missions, and they generally have altruistic and compassionate motives. I think that this can be said for most people who enter the health care field, faith-based or not. But I believe Catholic health care is better at attracting these people and aligning them to its mission.

My impression is that our recruiting processes are not particularly strong, but our mission is a magnet for compassionate caregivers and for those who support caregivers. Consistently, the systems that we have worked with in formation and assessment activities demonstrate very high scores on their employees' ability to see how their work supports the mission of the organization. This alignment taps into a discretional energy that positively impacts the level and nature of care.

I believe that this alignment is Catholic health care's "secret sauce" and is a critical ingredient in how formation programs are designed. Such an alignment of fundamental associate motives to mission is embodied in many of the founding myths of Catholic health care's sponsors. While retaining our specific founding myths, successful formation activities use these founding stories as examples of responses to Jesus' healing mission and challenge current leaders to respond in new ways to that same mission.

Care for Poor and Vulnerable Persons: Not surprisingly, this principle stands out as an attribute of Catholic health care in many assessments. The principle usually is well articulated in organizations' mission and values statements and in strategic planning throughout the ministries. The principle's implementation is not limited to caring for the poor who come to Catholic health care institutions, but it also actively seeks out and understands those living in poverty so that their needs can be met. The principle is so prevalent in planning documents that it is sometimes mistaken by employees as the sole component of Catholic health care's mission.

In the markets in which we have conducted assessments, leaders and caregivers tell us that it is this principle that most often differentiates Catholic health care from others. To be honest, I must report that many ministries do not identify this principle as a strength. Although they recognize the good that has been done, they seem challenged by all that is left to be done.

One inner-city ministry, consistently a financial loss for its parent system but maintained as an outreach to those living in poverty, rated itself very low because of all the needs it saw that it could not respond to. There was a constant attention to wanting to do more.

Successful formation efforts for the principle of care for poor and vulnerable persons have used the Gospel message of compassion, the church's teachings on justice and the institution's own founding myths to inspire all levels of leaders and associates to commit to the healing ministry. Through the lens of such commitment, leaders and associates can determine how each of their unique sets of skills and abilities can be put to use to implement how they serve on a daily basis. Robust community needs assessments become the organizational blueprints for how these skills will specifically be put into practice. And, although we must remain open to continued improvement in how we attend to and advocate for those living in poverty, it is also appropriate to reflect on and celebrate our successful service to them.

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Stewardship: Another evident strength of Catholic health care is stewardship. This is one area in which the gifts of the laity have had a particularly profound impact. In a heavily regulated, high-volume, low-margin industry, the leaders of Catholic health care institutions have navigated a course for their institutions that has kept their ministries solvent for decades.

Whereas mission and margin sometimes were viewed as antithetical, enlightened stewards of the healing ministry see margin as an empowering component of mission. In this view, margin is an energizing agent by which the ministry is graced.

Assessment activities regarding stewardship have allowed those engaged in the business aspects of our operations to see more clearly that

their work is a critical component of the ministry. It gives them a deeper sense of meaning. Successful formation programs assist leaders in viewing their financial expertise as gifts that they bring to the ministry.

Also, many institutions have embarked on a total quality journey to continuously improve their clinical and administrative processes. These initiatives ensure excellence of service and require very rigorous implementation efforts.

Successful formation in support of continuous process improvement emphasizes the spiritual attributes of attentiveness to the needs of those being served, a constant striving to be better and an openness to seeing our failures. Formation participants learn that continuous improvement is spiritual because of the improvement's purpose (furthering the healing ministry), because of the personal introspection required to sustain improvement processes and because their operational talents are identified as gifts given in support of the ministry.

OPPORTUNITIES

Employee Engagement: Although Catholic social teaching calls for a participatory workplace in which the workers have a voice in decisions that affect them, the Catholic health care ministry struggles to implement this type of culture. Associate engagement in health care at large remains at an industrial-age level, with leaders being primarily responsible for the design of work processes, while in many other industries, frontline associates are empowered regarding how they do their work.

Consider how little voice frontline caregivers in most of our hospitals have in decisions that affect their work. Clearly, there are exceptions — hospitals that have implemented a shared governance structure for their nursing functions typically score much better on associate engagement surveys. And, institutions that are deeply committed to a total quality workplace often have reached higher levels of engagement.

Respect in Action: Applying Subsidiarity in Business,[1] published by the University of St. Thomas, is an excellent resource for understanding this principle. It includes the following quote by William Pollard, former CEO of ServiceMaster:

"It is wrong to steal a person's right or ability to make a decision. If we do so, it will ultimately cripple the firm. ... Delegation and decision-making at the point closest to the customer is imperative. Delegation without a framework of authority will lead to chaos."

Successful formation in the principle of subsidiarity will emphasize the inherent dignity in each individual we invite to work in our ministry, and it will call for responsible creativity in addressing how we improve our service.

Attend to the Whole Person: Another opportunity for improvement in Catholic health care is how we care for the whole person. For me, this area exhibits the greatest divergence between our practice and our theology. Based on our view of the human person as an integration of body, mind and spirit, we call for a healing model of care that addresses those aspects in a complementary, integrated manner. But most of the care we deliver is based on a scientific model that treats the physical component as a detached element of the patient.

There are clear exceptions. Hospice, palliative care and many oncology programs treat patients holistically. But those represent a relatively small portion of our care, and many physicians still are reluctant to refer patients into hospice and palliative care.

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The January-February 2018 issue of *Health Progress* provided excellent insights into mental health issues, including making mental health more of an integrated component in the care model. However, the discussion was more of an aspiration than a description of the current state. In his article "Integrating Care of Mind and Body,"

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writer John Morrissey states frankly, "The separation of physical and behavioral systems of care is a longstanding obstacle."

Some care models like "relationship-based care" have demonstrated effectiveness at addressing emotional needs, but they have not been implemented broadly across Catholic health care. One gauge of how well we are treating the whole person is how willing patients are to recommend our ministries as places to receive care.

Interestingly, research has shown that there is a strong relationship between our patients' willingness to recommend us for care and our associates' willingness to recommend us as a great place to work. How we care for the caregivers has a powerful impact on how they care for patients.

WHERE TO NOW?

Just as we have learned from our experience with the implementation and refinement of formation programs, we also must take heed of what our ministry assessment processes are telling us and make improvements accordingly. Not all of the recommendations coming from our assessments will involve formation, but many will. And a regular review of our formation activities to ensure inclusion of the principles in our "Shared Statement of Identity" will be useful.

Although our assessments of our care for poor and vulnerable persons are typically strong, we always must retain an emphasis on this Gospel imperative in our formation programs. It is who we are.

Creating a just workplace will continue to require a respect for the human dignity of our associates and a balance between proportional compensation structures and stewardship of our fiscal viability. That said, I believe that the most important lesson we are learning from our assessment activities is the need to hear our associates' voices in decisions that will affect how they work. This requires not only processes for hearing the concerns of workers, but also a leadership disposition to be open to input and a willingness to delegate authority to the lowest appropriate level.

Developing leadership's trust in the lower echelons of the organization is as much a spiritual issue to be addressed in formation as it is a human resource issue to be addressed in policy. It requires a sincere look at our humility as leaders and our willingness to allow others to assume power.

The quality of people attracted to Catholic health care can be leveraged through workplace spirituality programs that help workers align their skills to the needs of the ministry and foster the courage to identify opportunities to improve. Workplace spirituality programs for direct caregivers and other frontline workers also emphasize the responsibility to identify and actively participate in improvement opportunities.

BILL BRINKMANN is a consultant to the health care ministry. He formerly served as vice president for mission initiatives at Ascension Health, St. Louis, with responsibility for leadership formation, Catholic identity assessment and patient experience.

NOTE

1. Michael J. Naughton et al., *Respect in Action: Applying Subsidiarity in Business* (St. Paul, Minnesota: UNIAPAC and University of St. Thomas, 2015.) www.stthomas.edu/media/catholicstudies/center/ryan/publications/publicationpdfs/subsidiarity/RespectInActionFINALAfterPrinterProof.withcover.pdf.

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