

Let Justice Flourish



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The work of justice is often countercultural, requiring us to speak out against practices and policies that keep others from flourishing in community. Yet this work is indispensable in living out the Church's mission.

At the Catholic Health Assembly in June, more than 1,200 leaders of the Catholic health ministry came together to explore a variety of topics related to justice, especially what we as a ministry can do to ensure all Americans have accessible and affordable healthcare. In this special section, *Health Progress* shares the challenges and solutions presented by an esteemed roster of experts. In so doing, we hope to extend the assembly's goal: to strengthen your ability to ensure that our own ministry of healing, as well as the broader healthcare system in this nation, reflects a stronger commitment to justice.

Institutions Have Power To Promote Justice

Healthcare Needs to Ask Itself Tough Questions, Particularly Whether Its Power Derives from a Fear of Death

In her keynote address, **Margaret O'Brien Steinfels** outlined the complex issues embedded in the struggle to achieve justice. But, she warned, "life is unfair," and part of the maturation process means learning to live with certain inequities and injustices in our lives that cannot be redressed.



"When market criteria govern the way you organize and run your hospitals, does the demand for efficiency always trump the claims of justice?"

Margaret O'Brien Steinfels

Institutions have played a critical role in establishing and ensuring justice, even as political forces are dismantling and weakening institutions. Steinfels, editor of *Commonweal*, cited Martin Luther King Jr.'s leadership in making the black church in America an instrument of justice for the whole country. "When Martin Luther King Jr. came along, the equation changed, the balance shifted. He exposed the enormity of these injustices and gave voice to justice," she said. Basing his message on the Bible, the Declaration of Independence, the U.S. Constitution, and the Bill of Rights, King made a compelling case: "If you believe in these things, then segregation must end. Americans,

Christians, and Jews could no longer go on living a lie."

Institutions have the power to surface the deepest beliefs of collective conscience and "make us see things differently." But, Steinfels warned, the struggle for justice is potentially delusional, and she asked assembly-goers to consider some tough questions about the healthcare delivery system. "When market criteria govern the way you organize and run your

hospitals," she said, "does the demand for efficiency always trump the claims of justice? Do the least powerful people in your institutions get a fair shake when the budget is put together, when personnel policies are formulated? Do the most powerful always have the final say on disputed questions?"

Steinfels deplored the healthcare delivery system's constant refrain of "limited resources and near bankruptcy" when it represents nearly one-fifth of the gross national product. Instead of questioning why they are so weak and on the verge of collapse, healthcare institutions should be questioning why they are so powerful.

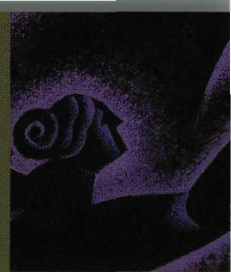
"More than any other institution in America, except, perhaps, the prison system, the medical care system commands enormous resources and can compel legislators, regulators, and insurers to do a good deal of your bidding. You may feel besieged, but you are privileged in ways that many others are not," she told assembly-goers.

Fear of death gives the delivery system its enormous resources and power, Steinfels suggested. "It is a fear you can never assuage. Is this a power you really want?"

For Catholic institutions to truly redress the inequities in the healthcare system, they must confront the "idea that medicine will make us immortal. In the Catholic scheme of things, death is not the end of life; death is part of life," she said. This belief challenges Catholic institutions to rethink how they care for persons whom medicine cannot help and to incorporate care of the soul as thoroughly as care of the body.

"Just as Americans changed their minds and practices about race, we can change our minds and practices about how we live the end of life," she said. "Our deepest beliefs . . . must begin to penetrate our consciousness and guide our actions. Both life and death are part of God's creation. We need to recover and reappropriate that profound biblical sense that God gives and God takes away, that our efforts to bring justice are but echoes of the justice and mercy which God has already given us."

Ministry Can Lead Healthcare Transformation



Catholic Facilities Can Bring About Social Change as Providers, Insurers, Employers, and Advocates

Citing society's failure to deal with its most vulnerable, **Sr. Doris Gottemoeller, RSM**, chair of the Catholic Health Association's (CHA's) board of trustees, told members of the Catholic health ministry that they were



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Sr. Doris Gottemoeller, RSM

"uniquely positioned" to lead a movement to shape a more compassionate and just healthcare system in the United States.

"Catholic providers have been called the conscience of healthcare in this country, presumably because we are effective in raising significant issues and demonstrating effective responses," Sr. Gottemoeller said. "I daresay we are the most significant counterweight to the commercialization of healthcare." She said Catholic healthcare leaders in four interrelated areas—service providers, insurers, employers, and advocates—can unite to create social change.

As service providers, she continued, CHA members include 532 hospitals and 319 long-term and continuum-of-care facilities, which daily live out their mission by providing high-quality care, reaching the poor and underserved, and offering spiritual care integrated with medical

services. To constitute a force for social change, the ministry must "use our combined strength to create a public perception, a corporate image, of what health-

care can and should be."

With 66 HMOs under Catholic auspices covering 3.4 million lives, managed care is one of the newest tools enabling Catholic healthcare to bring about social change, Sr. Gottemoeller said. While some managed care plans are only in it for the money, making the public skeptical of the system, Catholic healthcare "can insist on the values which managed care is designed to promote," including improved individual and community health through better use of preventive measures, better coordination of care, better use and allocation of resources, and enhanced influence on public policy.

CHA members can be instruments of social justice through their relationships with their more than 700,000 employees. From a justice perspective, Sr. Gottemoeller said, "our obligation to our employees might exceed that to our patients." Workers should enjoy the right to participate in decisions that affect their employment and should receive wages and benefits commensurate with their contribution to the ministry, she said.

Catholic healthcare's advocacy work includes its service to the vulnerable and underserved. By also speaking out in the public policy arena, Catholic healthcare can focus on the systemic causes of poor health, including poverty, substance abuse, inadequate education and housing, and poor distribution of resources. "Our present system is failing too many people to be any longer tolerated," Sr. Gottemoeller said. "And the fact that this is occurring at a time of unprecedented prosperity must be a cause of shame and embarrassment to this country."

Sr. Gottemoeller chided critics who argue that the Church should not be involved in healthcare because it has become "nothing but big business." Such people maintain it is impossible to be part of such a vast system without becoming tainted by greed and self-interest. But Catholic healthcare's legacy, values, and vision "all give us a credibility in the public arena," she said.

What the Catholic Social Tradition Brings To Healthcare Reform

Catholic Social Teaching Serves an Important Countercultural Function But Also Has Some Weaknesses



"Catholic healthcare brings to the table, even in a 'public' conversation, the many voiceless and too often faceless victims of the status quo."



Lisa Sowle Cahill, PhD

For a complete text of Dr. Cahill's speech, see p. 18.

In the struggle to ensure healthcare for the uninsured, Catholic social teaching lends strength to the mission in a number of ways, most notably by serving a prophetic, countercultural function, said **Lisa Sowle Cahill, PhD**, professor of theology at Boston College. "Catholic healthcare brings to the table, even in a 'public' conversation, the many voiceless and too often faceless victims of the status quo, whom it is easy to exclude and even forget because, on their own, they do not have the power to get through the door."

On the other hand, she said, the Catholic social tradition also has some weaknesses in relation to healthcare, including:

- ▶ The tendency "to advance broad ideals while downplaying the fact that realizing them in practice may involve conflict and compromise"

- ▶ An inclination to approach social justice and change in a hierarchical manner, rather than adopting a grassroots orientation in which advocacy for the rights of the disadvantaged is led by the disadvantaged themselves

- ▶ A decidedly Western European bias that can prevent us "from authentically hearing and appropriating the faith experiences, moral values, and social needs of persons in other cultures." For example, the call for "universal access," while admirable, obscures the fact that, because of America's history of slavery and its continuing racism, black people and white people often have different healthcare needs.

While laudatory of CHA's efforts, Cahill cautioned that the achievement of accessible and affordable healthcare "goes against the grain of American individualism and of the market, and that Americans may be far from prepared to accept this vision, even as an ideal." She also warned that reform efforts will require "negotiation and cutbacks, reallocation of funds, and curtailment of benefits that some have come to expect or already take for granted."

Justice Can Flourish through Politics

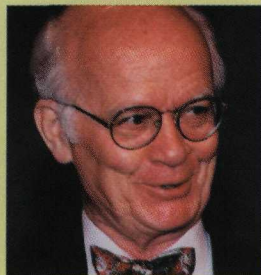
A Theologian Outlines Six Steps the Ministry Must Take in Its Search for Justice

As CHA embarks on its goal to build a national consensus on the need for healthcare for all, we must not forget the link between spiritual life and politics—not political parties, but *polis*, the "human city," asserted

Rev. Martin E. Marty, PhD, director of the Public Religion Project at the University of Chicago. The search for justice is a daily venture as well as a long-term plan, he said. "One does not wait three years, find a magical spiritual and prophetic consensus, and then start putting it into action. One 'lets justice flourish' in personal, Catholic, institutional, and national life, now

and constantly, while working to build consensus.”

Citing Psalm 72 as the source for the assembly theme, Marty pointed out that the psalm was originally to a king. Since we no longer live under a monarchy, “for whom in our prayer and our prophecy are we asking



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Rev. Martin E. Marty, PhD

ing that justice be effected, so that it flourishes?” For the answer, he said, “Look around you. Sixty-one percent of our citizens are outside the range of healthcare, and even those who are covered may not have just coverage.”

Marty outlined six steps in the search for justice that will enable it to flourish through us as a nation. “First you must discern—see—the situation of the needy and oppressed.” After discernment, “Prepare the soil,” Marty urged. Before we build consensus, we acknowledge God as the source of justice and humans as his stewards. We recognize, in Pope John Paul II’s words, “*dig-nitatis humanae*,” and that healthcare is essential to the realization of human

dignity and justice. We must also see that the search demands dialogue with others—conversation, not argument. Then we are ready to plant the seeds of justice.

The vital role religion plays in society then cultivates an environment in which justice is allowed to flourish. “Religion brings to political and policy discourse not only reason, but elements that religion nourishes as people make decisions: intuition, memory, community, tradition, hope, and affection [in the sense of an ‘affective’ life together] as part of its role in society.” But we must also counter that which inhibits the flourishing of justice: the idea that religion plays a marginal role in America’s secular society, or that Americans’ spirituality is too individualistic for them to work for the common good and justice. It is incorrect to call ourselves a strictly secular society, Marty said. “We are a religio-secular society. We are seeking” spirituality. We may be individualistic, but “our web of affiliations is strong, and building community is absolutely essential if justice is to flourish.”

Finally, we must nurture justice as it flourishes, by looking for renewal in its sources; through criticism, including self-criticism; through witness and gesture; and through immediate action along the way.

Politics, the work of the “human city,” works through many elements to let justice flourish, Marty concluded. It works through the individual; through the institutional voice of the Church; through agencies of the Church, such as CHA; through society, in consensus building; and through the rest of life. But politics has its limits, too: the eternal, and that which transcends even justice.

Strategies for Healthy Systems

Cosponsorship Ensures Ministry’s Future

Mutuality, Not Proportionality, Underlies Cosponsorship Effort between Daughters of Charity and Sisters of St. Joseph

Many of the recent healthcare mergers, affiliations, and other collaborations have been driven by concerns about the continued viability of a particular facility. Not so with the cosponsorship agreement reached by the four provinces of the Daughters of Charity and the Sisters of St. Joseph.

In describing the arrangement, **Sr. Janet Fleishacker, SSJ**, president of the Sisters of St. Joseph, Nazareth, MI, explained that “this partnership only makes sense in the context of the broader perspective about the continuation of the mission and ministry into the future.”

This is particularly true for the Daughters of Charity National Health System (DCNHS), St. Louis, which will be entering this cosponsorship arrangement with the much smaller Sisters of St. Joseph Health System, Nazareth, MI. **Sr. Xavier Ballance, DC**, DCNHS board chair and a sponsor representative from the East Central province, explained that some people in the sys-



Sr. Xavier Ballance, DC

tem have accused the sponsors of "giving away the store." But, inspired in part by the *New Covenant* movement for collaboration within the ministry, the sponsors' concern goes beyond the continuation of an individual charism and focuses on the healing ministry of Jesus, she said.

The cosponsorship arrangement will bring together two congregational traditions, two health systems, and five sponsors into a new Catholic health system. The two speakers stressed that the agreement between the five sponsors is based on "mutuality of influence," not proportionality. The new system's sponsors' council will include one representative from each of the four Daughters of Charity provinces and four representatives from Sisters of St. Joseph. In addition,

two laypeople will serve on the council to further help it transcend the religious congregations.

The steering committee that is developing the new sponsorship and governance structure, in addition to working on business issues, is also building relationships and candidly discussing feelings about the arrangement. "With the volume of work involved, we are guarding against it becoming just a task and a mound of papers," said Sr. Fleishhacker.

The steering committee has developed a mission and vision and a set of core values that involved input from persons at all levels in the organizations involved. They make decisions by consensus and constantly ensure that they are adhering to the guiding

principles they've established. "The main thing is to keep the main thing the main thing," Sr. Fleishhacker said. "If we meet a stumbling block, we can look at our principles and see that this is not the main thing."

They have also established task forces to share the practices of each health system and congregation so they could retain the best of both. "It's not about deleting our heritage or selecting a dominant heritage,"

explained Sr. Fleishhacker. "What comes forward needs to build on both and be able to accommodate others that might want to join later." Sr. Ballance explained that several other systems have expressed interest in joining, but they are deferring discussions until the current planning is complete.

CEOs Share Secrets of Successful Growth

Cultural Compatibility and Market Position Are Important Factors When Expanding a System

Bon Secours Health System, on the East Coast, and Catholic Healthcare West (CHW), on the West Coast, have both experienced rapid and successful growth in the past few years. These two systems' presidents and chief executive officers (CEOs) explained how their systems' strategies have emphasized community or regional growth, physician integration, and compatibility between cultures, thereby enabling the two systems to sustain rapid change in the shifting healthcare environment.

Christopher M. Carney, president and CEO of Bon Secours, Marriottsville, MD, outlined how that system has grown, what it has learned from that growth, and what may lie ahead. In 1990 the system had five hospitals and \$541 million in assets; as 2000 approaches it has 17 hospitals and \$1.3 billion in assets. It has seen great growth in nonacute services, a development that Carney said was "unintentional" but reflects the Bon Secours mission of holistic care.

Bon Secours's growth has primarily been the result of partnerships with both Catholic and other-than-Catholic providers. "Our goal is to be the number one integrated delivery system in every community we serve," said Carney. To that end, Bon Secours has added assisted living facilities, behavioral health centers, and long-term care facilities to its acute care hospitals.

In the course of this growth Bon Secours has learned valuable lessons. "One size does not fit all," warned Carney, explaining that cultural synergy between proposed partners is critical. Bon Secours assesses opportunities in terms of whether they will increase sponsor and mission presence in the community, promise to establish Bon Secours as first or second in the market, and add operating synergies. "Not every deal should be done," Carney pointed out. Say no when you sense cultural incompatibility, divergent expectations, or a weak business case for the move, he advised.

Richard J. Kramer, president and CEO of CHW, San Francisco, oversees a system that has focused on regional growth. From a 10-hospital system, CHW has



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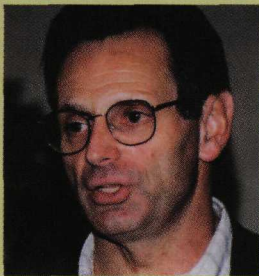
Sr. Janet Fleishhacker, SSJ



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particularly a focus on community services; they must have a strategy for aligning with physicians; and affiliation must strengthen the regional system and be financially viable. This regional growth in turn expands CHW's mission, reduces general costs, and enhances specialty centers. CHW's physician strategy, too, is regional rather than local or systemwide. "If the



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grown to a 48-hospital system in 10 regions. Its current revenues are approximately \$4.4 billion; current assets are approximately \$5.7 billion.

Like Bon Secours, CHW's strategy when adding facilities to the system is to be first or second in the market. It has built regional delivery systems of hospitals, medical groups, ambulatory services, home care, and long-term care in the San Francisco Bay region, the Sacramento region, and Southern California.

Kramer outlined CHW's criteria for potential partners: They must share CHW's values, particularly a focus on community services; they must have a strategy for aligning with physicians; and affiliation must strengthen the regional system and be financially viable. This regional growth in turn expands CHW's mission, reduces general costs, and enhances specialty centers. CHW's physician strategy, too, is regional rather than local or systemwide. "If the contracting is regional, the risk-taking has to be regional as well," Kramer added.

CHW has learned that partnerships must be relevant to the marketplace and "meaningful to buyers of healthcare," Kramer continued. "You must understand the needs of your constituencies." Second, it is important to address all the expectations of those involved. "Everyone has different expectations, but they don't necessarily tell you until after affiliation." Getting these out in the open means conflicts can be resolved at an early stage. Third, CHW bal-

ances centralization and decentralization by considering what is best for both the system and the region. Finally, "change management resources are essential," said Kramer. In an environment of rapid change, don't hesitate to use both internal and external resources to help people cope.

Making Provider Health Plans Work

Instituting a System-Owned Health Plan Is the Right Thing to Do But Can Lead to Conflict

Provider-owned health plans are attractive for a number of reasons, but their development and success are expensive and difficult to achieve and maintain, according to **Judith C. Pelham**, president and CEO, Mercy Health Services, Farmington Hills, MI, and **Henry G. Walker**, president and CEO, Sisters of Providence Health System, Seattle. Pelham and Walker candidly spoke about some of the problems their systems have encountered with their health plans.

"It's the right thing to do for all the right reasons," said Pelham. Mercy Health Services, which has approximately 260,000 members in its health plans in Michigan and Iowa, was attracted to ownership of managed-care plans for several reasons, including increased control over premiums, fees, medical operations, and administration; the ability to appropriately allocate funds; and the opportunity to fill in gaps in the system. For Providence Health System, whose health plans have become a \$7 million operation, "soft" reasons to become an insurer included a commitment to healthier communities and the desire to address critical issues such as cost, quality, and access, particularly access to basic healthcare services, said Walker. "Hard" reasons were the fact that "we wanted to move up the food chain" and become a bigger player in the healthcare market.

Developing a provider plan is not easy, both Pelham and Walker warned. "Integration is hard," said Walker. "Provider services and provider plans are different businesses" in their fundamentals and in their incentives, and this can lead to conflicts with physicians. Furthermore, he pointed out, running an insurance company is expensive. It necessitates taking on risk, it is a cyclical business with large ups and downs, and it requires both reserves and capital growth.

Pelham also noted the possibility of plan-provider conflicts—"and it's difficult to negotiate your plan with your physicians." And as the plan grows, competition with other insurers is fierce. At one point, Pelham recalled, "we couldn't feed our



Employers are looking for "price, price, price, quality, and data—and only recently have they added the last two."



Judith C. Pelham

provider network with our own product, so we needed other insurers. However, they were offended by the fact that we were also competitors." Explained Walker, when you become a player in the insurance market, "insurance companies with whom you have provider contracts want you to fail and will try anything they can to move business from you." Other problems include deciding where profits will be recorded and the fact that information systems and data are "never good enough," added Pelham.

Employers, too, are



Henry G. Walker

adding pressure on insurers. Pelham drew on her experience with Ford Motor Company and General Motors to describe what employers are looking for: "Price, price, price, quality, and data—and only recently have they added the last two." The economic boom

of the late 1990s has supported employees in their demands for greater choice and increased services, and large employers now demand accountability and measurements from plans. Ford and General Motors have amassed huge amounts of information on health plans, which they pass along to their employees, and Pelham foresees increasing demand for demonstrably high-quality, cost-effective plans.

Concilia Moran Award Goes to Sr. Mary Roch Rocklage



Sr. Mary Roch Rocklage, RSM

Photo by John LaFata

Throughout her remarkable and distinguished career, Sr. Mary Roch Rocklage, RSM, the recipient of the 1999 Sr. Mary Concilia Moran, RSM, Award, has strengthened the Catholic health ministry by embracing and facilitating change. The award honors the commitment and visionary leadership of an outstanding member of the Catholic health ministry.

At the time of the award presentation, Sr. Rocklage was the president and CEO of the Sisters of Mercy Health System—St. Louis (SMHS), a system that owes its beginnings to her efforts to formally bring together all the healthcare facilities sponsored by the Sisters of Mercy—St. Louis. On July 1, 1999, Sr. Rocklage became board chair of SMHS. Her ability to help healthcare leaders and religious congregational leaders understand and articulate their common mission resulted in the creation of SMHS in 1986.

Sr. Rocklage leads a health system that today spans eight states, embraces diverse cultures, and serves needs in urban and rural areas. It consists of 23 acute care hospitals, a psychiatric hospital, more than 700 physicians at more than 180 sites, 58 freestanding outpatient facilities, a managed care corporation, and health and human service ministries. The system has more than 28,000 employees and 5,000 medical staff members.

In the early 1990s, Sr. Rocklage again was a force for change when she pioneered the system's move into healthcare financing. Mercy Health Plans, formed in 1994, currently operates in Missouri and Texas and provides coverage for more than 120,000 people. Under her leadership, the system welcomed its first non-Catholic members—a Presbyterian hospital and an Episcopal hospital. Sr. Rocklage's vision, extending beyond inpatient acute care to healthier communities and health education, has led to the establishment of numerous clinics and outreach services, including clinics in Belize.

Sr. Rocklage's efforts to bring about systemic change to benefit the poor and underserved have led to her service on the governing boards of numerous hospitals and health and education organizations. She also serves on the Domestic Policy Committee of the U.S. Catholic Conference, the American College of Healthcare Executives, the Forum of Women Healthcare Leaders, and the Forum of Healthcare Planning.

The Leadership Edge

Building Collaborative Relationships between Bishops and Laity Catholic Bishops and Healthcare Facilities Can Teach and Learn from Each Other

Relationships between lay leaders of Catholic healthcare and the Church—in the form of diocesan bishops—should not be “relationships of control,” explained **Zeni Fox, PhD**, but relationships of “sharing,



“All of us bishops need an education in the pressures you in healthcare face.”

Bp. John J. Leibrecht, DD, PhD

collaboration, and trust.” Establishing such relationships is a matter of mutual learning. “All of us bishops need an education in the pressures you in healthcare face,” said **Bp. John J. Leibrecht, DD, PhD**, while the bishop’s role, he proposed, is to help coordinate Catholic healthcare within the whole mission of the Church, to see how it “fits in.”

Fox, director of lay ministry and associate professor of pastoral theology at Immaculate Conception Seminary, Seton Hall University, South Orange, NJ, said the recent shift in leadership of Church ministries

from primarily clergy and vowed religious to the laity has been “dramatic.” It has happened over only the past 40 years and inevitably has raised questions concerning the preservation of Catholic identity and the protection of the patrimony of the Church, which is “more than assets. . . . It includes the Church’s historical role and its credibility in the community.”

Bp. Leibrecht’s experience illustrated Fox’s summary. Ninety-five percent of the parochial school staff in his diocese—he is bishop of Springfield–Cape Girardeau, Springfield, MO—is now lay, and the five Catholic hospitals and health facilities in his diocese are all directed by Catholic laity.

Bp. Leibrecht’s experiences with the healthcare facilities in his diocese have ranged from his being completely “out of the loop” in major decisions to his being actively involved. “I appreciated being consulted,” he said. “I have something to add—I think most bishops do—and we can do that in a way that will be helpful.”

A bishop has an important role to play in the pastoral life of the institution, he continued. A bishop is “both a communicator and collaborator,” and as a teacher can help Catholic healthcare facilities with questions of identity or interpretation of the *Ethical and Religious Directives for Catholic Health Care Services*. “We’re there to work with the institution” and with its ethicists, “to help them know what the Church teaches.”

Mission Integration Starts with the Board

When Three Systems Came Together as Catholic Healthcare Partners in 1997, They Saw New Opportunities for Integrating Mission

As sponsors move from frontline to oversight responsibility, more and more of the responsibility for ministry stewardship is being delegated to governing boards. To better prepare for the shifting responsibilities—and for additional cosponsors—Catholic Healthcare Partners (CHP), Cincinnati, revamped its board structure and functions.

At the heart of the new approach to governance was the need to integrate mission at all levels of the organization, especially the board. In 1997 a governance task force comprising representatives from the three health systems that formed Catholic Healthcare Partners in 1997 pointed the way. Task force members recommended combining the 27 mission statements from the systems’ various entities into one mission statement and collapsing the separate corporate board and corporate member into one governing board.

But the changes in governance at CHP went far beyond structure, according to **Sr. Beverly McGuire, RSM**, executive vice president, and **Michael Connelly**, president and CEO. The restructuring carried with it a new understanding of board member

roles and commitments. A big responsibility for board members is to be active, Connelly said. "While we've made it an honor to be part of the board, it's not an honorary position."

Board members begin their terms studying the *Ethical and Religious Directives for Catholic Health Care Services*. "Everyone knows three of the directives," Sr. McGuire observed. "We were interested that they know those three and the other 67, which is the real call to Catholic identity. We used the directives to make it clear to folks what we do, for whom we do it, and in whose name we do it."

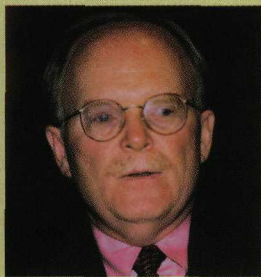
Another expectation is that the board focus on the future, rather than just operations. Meetings, for which members receive and read advance information, have a set format to keep them running well and to allow time for strategizing. Board members also routinely meet in executive sessions. "You need these sessions periodically to maintain objectivity," Connelly said. The board furthers its own education through CHP University, a series of facilitated modules on issues critical to governance.

CHP's annual trustee seminar is a bit like the Catholic Health Assembly, Sr. McGuire said. "Last year we took a leap and did more of a motivational

seminar. It was about spirituality. Our board members are looking for the motivation to do the tough stuff like the BBA [Balanced Budget Act] implementation."

CHP's board has cultivated itself as a learning organization by developing "evidence," or measures, for everything it says it values. "We all know what it means to be an AA bond-rated organization, but do we know what it means to be an AA-rated care of the poor organization? In the absence of standards, anything becomes acceptable," Connelly observed.

At CHP both the board and the system CEO have objectives and measures for meeting those objectives that they have all agreed on. "We need good information so that we can say with some comfort that we're doing what we signed up to do," said Connelly.



"While we've made it an honor to be part of the board, it's not an honorary position."

Michael Connelly

Fine Tune To Become a Peak Performer

Leaders Challenge Themselves and Others to Embrace Change, Apply New Skills and Knowledge

The difference between leaders and peak-performing leaders is less a matter of effecting incredible change, than of fine tuning.

In an energetic presentation interspersed with music, sound effects, and sports analogies, **Bob Moawad**, CEO of Edge Learning Institute, Tacoma, WA, told assembly-goers to rein in endless amounts of research about your direction and "get off the launch-pad." You can always get feedback about what you are doing and correct your aim accordingly, he said. Although his topic was developing board competencies for the new millennium, Moawad's message clearly applied to individuals at all levels of the organization. "Everyone should behave like mini-CEOs," he said.

"The main demands for leadership are guts and judgment," according to Moawad. "We'll be remembered more for our success than our failures, and yet our number of successes is directly proportional to the number of our failures." Moawad underscored his point with stories of Major League sluggers Babe Ruth, Reggie Jackson, and José Canseco, all of whom had strikeout statistics that rivaled their home run records. "It's the willingness to go to bat" that made them achieve their successes, he said.

An often overlooked resource for accomplishing organizational change is the people who work there. Merger activity reached an all-time high in January, according to Moawad, but statistics show that half will fail, and half of the failures can be blamed on the human factor. "It's important to understand that organizations don't fail—people do," he said.

Research shows that in a normal day people work about 4.8 hours; when an organization is in the midst of major change, 3 more hours are lost, as people worry, "What about me?" Leaders must confront other underlying blocks to peak performance such as assumptions that "we're OK the way we are," fear of the unknown, and fear of failure.

"The job of the leader is to let people know that change is just beginning and will never end. You need to emphasize teamwork and celebrate your victories," Moawad said.

Meaningful change must start from inside the individual, he asserted. The best way to begin is with an internal advertising campaign, changing the way one talks to oneself. "New skills and knowledge without a change in habits and attitudes cannot effect change. Knowledge does not equal power unless you can apply it and share it," he said.

Commercialization of Healthcare Called Bad Economics



The Market Approach to Healthcare Is "Inefficient and Self-Defeating," Journalist Tells Assembly

Arguing that the commercialization of healthcare is as wrong economically as it is morally, journalist **Robert Kuttner, PhD**, told a general session audience that government action will be required if the United States is to move toward coverage for all its citizens.

Kuttner, coeditor of *The American Prospect* and the author of a new book called *Everything for Sale*, said a market approach to healthcare is "inefficient and self-defeating."



"Some sectors of the economy have structural reasons that prevent them from following textbook economics—and healthcare is one of them."

Robert Kuttner, PhD

Although conservatives say healthcare is a business like any other, "some sectors of the economy have structural reasons that prevent them from following textbook economics—and healthcare is one of them," Kuttner said.

Although "textbook economics" applies to two-thirds of the U.S. economy, he argued, it does not fit healthcare for two reasons:

- ▶ The healthcare consumer is not sovereign. For one thing, most consumers lack the medical knowledge necessary to choose among possible providers. For another, most of the actual choosing of health plans is done by employers, not the consumers themselves.

- ▶ Healthcare organizations are not rational,

in the sense of seeking always to maximize profits. "In the modern world, we don't let people die in the streets," as Kuttner put it. Modern society forces physicians and hospitals to provide care even to people who cannot pay for it. As a result, the healthcare

consumer has been "de-linked" from healthcare products, invalidating classical economic theory.

Because healthcare consumers cannot discipline healthcare producers—as textbook economics says they should—government must do it for them, Kuttner argued. "A patients' bill of rights would be a good start."

Unfortunately, the current trend in healthcare is away from government discipline. "Even though traditional Medicare is the only system that still lets consumers make real choices," it remains fashionable to denigrate government involvement in healthcare and to praise the market. But commercialization is actually a destructive process, for two reasons:

- ▶ It wipes out the cross-subsidies that regulated healthcare used to provide for medical research and education.

- ▶ It encourages insurers and providers to limit their services to healthy people.

"The logic behind commercial healthcare tells practitioners to stop treating sick people," Kuttner argued. "It's the same logic as that followed by the hotel where we're staying. The hotel won't take guests who can't pay the price of its rooms. That's okay in the hotel business and other endeavors, but in healthcare it makes no sense."

Kuttner said the United States needs government-insured universal coverage and predicted this would come about, though only through a series of incremental reforms. He criticized both the Health Insurance Portability and Accountability Act (Kennedy-Kassebaum) and the Children's Health Insurance Program as "hollow victories" that further fragment an already fragmented system. It would be better to extend Medicare coverage first to all children, then to adults aged 55 to 65, then to all other adults, he said.

Market Forces Are Better Than Regulation

Tax Credits and Incentives Can Help Achieve the Goal of Health Insurance for All

Calling for a “market-oriented system with a human face,” **Jack Kemp** proposed that market forces, combined with full deductibility of health insurance premiums or, for low-income families, tax credits, will drive health insurance costs down and provide a way for the currently 44 million uninsured men, women, and children in the United States to buy into the healthcare system. Kemp, currently the codirector of Empower America, is a former congressman and a former secretary of Housing and Urban Development, and was a vice-presidential candidate in 1996.

“I won’t support a candidate who doesn’t believe we have to pursue justice for all races and ethnic groups.”

Jack Kemp

“We made a mistake” in the World War II period, Kemp said, when the government allowed employers to deduct from taxes the cost of health insurance for employees and the general expectation arose that business, subsidized by the government, would pay for health insurance. This has led to a “massive distortion” of the system, said Kemp, and disempowered both people and providers.

State governments’ attempts to solve the situation through regulations and requirements for minimum benefits have backfired, he continued, pointing out that in states that adopted such legislation the number of uninsured has actually increased. “Consumers need choice,” Kemp added, and should be able to purchase basic catastrophic coverage as well as top-of-the-line policies.

Kemp said there are “two simple things” Congress can do. One is to make the cost of health insurance premiums fully deductible to everyone, not just employers. If individuals purchase their own policies, increased competition among insurers would drive costs down. And if individuals own their own

insurance, that would solve the portability problem when they change jobs.

Kemp’s other proposed change is a tax credit of up to \$2,000 for low-income families’ health insurance costs. He cited the need for jobs for all, so that income would generate the ability to purchase health insurance, as well as education and housing.

“It is not possible for this country to go into the 21st century and leave 44 million behind without the justice of access to healthcare,” Kemp said. He pledged to work to influence the healthcare debate and urge others to sign CHA’s petition, which encourages presidential hopefuls to sign CHA’s pledge to make healthcare reform a priority (see story p. 10). Kemp, who has himself signed the petition, promised, “I won’t support a candidate who won’t take CHA’s pledge.” He also hopes to put CHA’s pledge in the Republican platform. “I won’t support a candidate who doesn’t believe we have to pursue justice for all races and ethnic groups.”



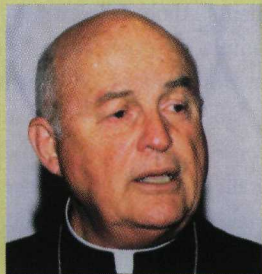
Petition for Reform Two prominent national figures—Jack Kemp (pictured above with Rev. Michael D. Place, STD) and Coretta Scott King—have thrown their support behind CHA’s healthcare reform agenda. At the assembly, both signed CHA’s *Be Heard* petition, urging presidential candidates to sign a pledge to make healthcare reform a priority. For more information on CHA’s healthcare reform agenda, see p. 10.

Justice in the Workplace

The Challenge of Unionization Catholic Healthcare Seeks Healthier Relations between Labor and Management

"We ought to see unions not as enemies but as allies," **Bp. Joseph M. Sullivan, DD**, told a session largely made up of executives and trustees of Catholic healthcare organizations. "After all," he continued, "both unions and Catholic healthcare leaders are dedicated to establishing fairness and justice in the workplace."

Bp. Sullivan, auxiliary bishop of the Diocese of Brooklyn and Queens, NY, and **Thomas Corley**, president and CEO of Lourdes Health Network, Pasco, WA, discussed the work of a task force on labor issues formed by the National Conference of Catholic Bishops. Both Bp. Sullivan and Corley are members of the task force—officially titled the Sub Group of the Domestic Policy Committee on Catholic Health Care and Work—whose final report will be published sometime next year.



"Both unions and Catholic healthcare leaders are dedicated to establishing fairness and justice in the workplace."

Bp. Joseph M. Sullivan, DD

Corley gave an outline of U.S. labor history, which, he argued, was essentially chaotic until the coming of Franklin D. Roosevelt's New Deal. In the years following the Civil War, law courts tended to favor business owners and to view workers' attempts to form unions as criminal conspiracies. But then in 1935 Congress passed the Wagner Act, establishing the National Labor Relations Board (NLRB) to adjudicate disputes between employers and workers. Between 1935 and 1947, union membership grew from 3 million to 15 million, Corley said.

Until 1974 healthcare workers were excluded from the NLRB's jurisdic-

tion, he added. Unions still are not common in healthcare organizations outside the Northeast. But with the budget constraints of the 1990s, healthcare employees are more willing to listen to the arguments of union organizers, Corley said.

"The papacy was in some ways far ahead of the United States in its thinking on labor," according to Bp. Sullivan. In his 1891 encyclical *Rerum Novarum*, Pope Leo XIII set out the rights of industrial workers. And Pope John Paul II strongly defended Solidarity, the Polish union movement, in its struggle against that country's former Communist government. Catholic teaching calls for "a fair and just workplace," Bp. Sullivan said. "However, it doesn't say how this is to be brought about."

Some Catholic leaders believe it is impossible to have a fair and just workplace without unions, Corley said. But the task force has decided that it will leave the question of union membership up to workers themselves. "There remains substantive disagreement among our members on the right to organize."

One disagreement concerns the NLRB. "For example, some union leaders say the NLRB is rigged against them because it deliberates so slowly," Corley said. "Justice delayed is justice denied, they claim." But history shows that the NLRB, or a similar mechanism, is necessary, he argued. "It's a safety net for both employers and workers. Without it, we would return to the old chaos."

Another debate concerns workplace elections approving or rejecting collective bargaining agreements, Corley said. Some union representatives argue that no formal election is necessary, that collecting the petition signatures of a majority of workers should be sufficient to establish a union. "But I for one favor actually holding secret elections," Corley said. "I think that, without them, there is a danger of intimidation. Employees should always have the right to vote for and against."

"We're looking for a healthier and more trusting relationship between labor and management in Catholic healthcare," Corley said of the task force's document. "But this is just a working paper the task force is writing. It's not a Magna Carta."

Worker Fulfillment Requires

Just Wages

A Wage Philosophy That Is Out of Sync with Corporate Culture Breeds Employee Cynicism



“There’s no Catholic cookbook on compensation issues that’s going to solve all the various problems that you’re going to encounter.”

Michael Naughton, PhD

As Catholic healthcare leaders develop a just system of wages, they foster a culture in which workers can develop to their full potential. But attaining just compensation is a difficult task, according to **Michael Naughton, PhD**, associate professor of theology, University of St. Thomas, St. Paul, MN. “Our incomes are like our shoes,” he said. “If too small, they gall and pinch us. If too large, they cause us to stumble and fall.”

Just wages must be in harmony with an institution’s vision and culture, Naughton said. If they are not aligned, “it will most likely generate a great deal of cynicism and bad faith.” Managers must understand that pay at its core has moral and spiritual

dimensions that relate to justice. He outlined three critical principles of just compensation: a living wage, an equitable wage, and a sustainable wage.

A living wage acknowledges the dignity of the person, the fact that employees are not merely “human commodities,” Naughton said. It is a minimum amount due every wage earner because he or she is a human being with a life to maintain and a personality to develop.

An equitable wage recognizes the worker’s contribution to the organization, honoring his or her talents and efforts. Determining equitable pay is a more complex equation, Naughton said, because it acknowledges that some people are due more pay because they work harder or have education, experience, skill, or decision-making ability that is more valuable to the organization.

Wages must also be sustainable, a calculation that takes into account an organization’s economic health. Some companies abuse this principle by claiming they

cannot pay living and equitable wages because they cannot sustain them over the long term, Naughton said. However, a prudent organization will look at the concept of sustainability when calculating fair wages for all.

To develop just compensation, Naughton said, companies need to articulate a pay philosophy that aligns with their mission, culture, and strategic goals; evaluate their present pay practices to fit their principles; and align pay practices with pay philosophy. However, the answer cannot be boiled down to a one-size-fits-all formula. “There’s no Catholic cookbook on compensation issues that’s going to solve all the various problems that you’re going to encounter,” Naughton warned. “Some of these general principles will guide us along.”

Workplace Justice Linked to Quality of Long-Term Care

Nurse Aides Need Better Pay, Improved Working Conditions, and Trust of Supervisors

Improving the care of residents of long-term care facilities is linked to the justice extended to nursing aides, according to two assembly speakers. “You cannot provide quality care without providing quality jobs,” said **Elma Holder**, founder, National Citizens Coalition for Nursing Home Reform, Washington, DC.

Nurse aides are on the front lines in providing direct care to residents. About 60 percent of aides quit their jobs after completing orientation, said **Barbara Bowers**, professor, University of Wisconsin School of Nursing, Madison. Most say they quit because they did not understand the difficulty of the job. Those who succeed are generally women with several children, solid organizational skills, and an ability to juggle many tasks at the same time.

Because of short staffing, aides must often “bundle” several tasks (changing clothes while taking care of bathroom needs, for example) to save time. Workers are rushed and cannot provide the quality of care that residents need, Bowers said. In addition, many aides live paycheck to paycheck. If a car breaks down, they do not have emergency funds to pay for repairs, which jeopardizes their jobs because they have no transportation.

Bowers said many aides distrust and fear management. They complain that managers do not value their input and sometimes cannot even recall their names, she said. Aides also need more training, Holder said. They are required to have only 75 hours of training, compared with barbers and cosmetologists who, in some states, are required to have 1,500 hours.

Nurse aides and residents have some suggestions

to improve quality of care, Bowers said. Many aides want to cultivate relationships with residents, ensure physical comfort, and personalize care—all of which require time, flexibility, and adequate staffing.

Long-term care residents also want time to develop relationships with family and staff, Bowers said. “The worst thing that could happen to many of these folks is turnover,” she said. When aides leave for better-paying or less stressful jobs, residents feel abandoned.

Residents also want workers to make more eye contact, provide gentle handling, share their personal lives, and occasionally break the rules to get them something they want, Bowers said.

These concerns often are not addressed because staffing is not sufficient, and workers must find ways to cut corners to be able to complete their assigned duties. With adequate staffing, aides have time to meet residents’ individual needs.



Explorations in Cyberspace At the assembly's CyberCafé, members were treated to demonstrations of CHA's Web site, help in surfing the Internet, and ice cream.

Neighborhood Initiative Garner Achievement Citation

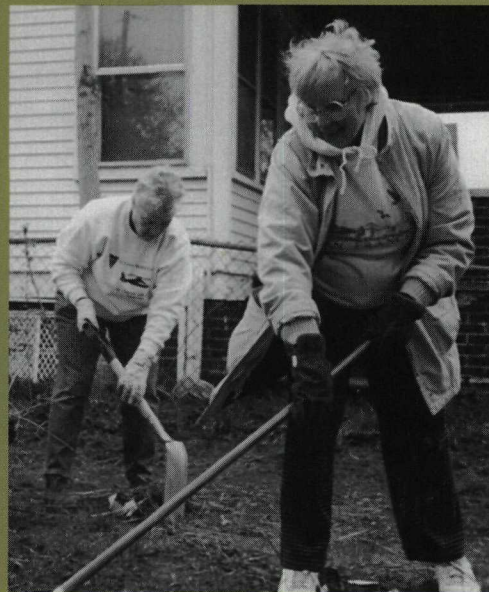
St. Vincent Mercy Medical Center, illustrating the Catholic health ministry's belief that healing involves neighborhoods as well as the people who live and work in them, has helped restore one of Toledo's oldest sections.

The Cherry-Bancroft-Summit area had fallen victim to the same ills that afflict older cities: shuttered businesses, abandoned buildings, increases in drug use and crime, unsafe streets.

St. Vincent Mercy Medical Center, a Cherry Street institution for nearly 145 years, resolved to help save the neighborhood. To that end St. Vincent and Mercy Health Partners (MHP), the system to which the medical center belongs, launched the Cherry-Bancroft-Summit Initiative, the 1999 winner of CHA's Achievement Citation. The initiative began by constructing a \$25 million ambulatory care center and medical office building. MHP also converted a 100-year-old mansion into its regional offices. In addition, the initiative:

- ▶ Acquired and demolished a score of abandoned buildings
- ▶ Helped establish a police substation
- ▶ Installed playground equipment at a neighborhood school
- ▶ Bought and restored a local Protestant church, thus helping rebuild its membership
- ▶ Played a leadership role in creating the Cherry-Bancroft-Summit Corridors Coalition, an organization for area residents
- ▶ Assisted St. Vincent employees in obtaining low-cost housing in the neighborhood
- ▶ Donated the labor of more than 100 St. Vincent employees in picking up litter from area streets and painting the homes of local residents

As a result of the initiative and other efforts like it, the neighborhood has attracted new businesses and the jobs that go with them. Last year, clearly demonstrating their faith in the area's recovery, builders constructed nearly a dozen new homes.



Administrative and staff volunteers at Mercy Health Partners help neighborhood cleanup.

In the Face of Crippling BBA Cuts, Healthcare Providers Need Strategies for Maintaining Mission



Sr. Geraldine M. Hoyler, CSC

All across the country, hospitals are reeling from the effects of unprecedented cuts in Medicare payments to hospitals and other providers resulting from the Balanced Budget Act of 1997 (BBA). Not surprisingly, more than a third of assembly-goers attending an interactive membership assembly cited ministry issues raised by BBA cut-backs as the most pressing challenge for the future of the ministry.

"We've simply got to learn to be more direct with representatives of Congress," one audience member said during an assembly session on the impact of the BBA. The audience member, a woman religious from Alabama, said her congressman recently told her, "Even though we won't increase Medicare reimbursements, you still have to find a way to take care of Medicare patients." "And I told him," the sister said, "the world doesn't work like that!"

The outspoken sister, and others like her, were responding to a presentation on Medicare cuts by Sr.

Geraldine M. Hoyler, CSC, senior vice president for finance and treasury, Catholic Health Initiatives (CHI), Denver. The cuts have already forced CHI to freeze staffing and capital spending, close some services, and combine some overhead costs, Sr. Hoyler said.

CHI is particularly vulnerable to Medicare cuts because, although it has \$6 billion in assets and 130 sites, many of those sites are long-term care centers, assisted care facilities, and home health agencies, Sr. Hoyler said. "We have relatively few big hospitals. A large proportion of our patients and clients are Medicare recipients."

The BBA cuts are reminiscent of President Richard M. Nixon's "economic stabilization" of 1971, she argued. "That program hurt because it froze the rate of reimbursements to hospitals. But the BBA cuts are worse because they are occurring at the same time as other big healthcare changes, such as the coming of managed care."

Still another complicating factor is a change in the government's system of coding illnesses for reimbursement purposes, Sr. Hoyler argued. "By April 2000 they'll have implemented APCs [ambulatory patient classifications]. To accommodate the government, healthcare organizations will have to update their information systems—and that will be expensive."

Sr. Hoyler predicted the BBA cuts will result in reduced staffs, consolidated agencies, and closed facilities across the nation. "I'm afraid we're going to see some parts of the United States go without home health altogether," she said.

Felicien "Fish" Brown, the session's moderator, reminded the audience that original estimates put the BBA's Medicare cuts at \$110 billion a year. "New estimates say the figure is closer to \$190 billion," said Brown, CHA's director for public policy. Sr. Hoyler said that, because of BBA cuts, CHI will lose \$80 million to \$100 million in revenue this fiscal year.

Brown urged CHA members to let Congress know that Medicare cuts are adversely affecting their ability to serve patients. "They'll increase reimbursements—but only if you push them," he said. However, a woman religious from Louisiana suggested that healthcare advocates should instead complain to congressional representatives about healthcare job losses caused by BBA cuts. "People in Congress tend not to get excited about lost services," she argued. "But talk about lost jobs gets their attention pretty fast."

Maintaining Catholic Identity

Be Assertive in Telling Your Story Effective Communications with the Media, Community, and Other Constituents Are Critical in Securing Community Support

Catholic healthcare leaders need to be “more direct about telling the community who you are, what you believe in, and what you do for them,” **Jack Bresch**,



“People think we’re trying to force our values on others because no one tells them why we’re doing the deal.”

Sr. Jean deBlois, CSJ, PhD

CHA’s director of legislative affairs, said in a breakout session. A more assertive approach to communications not only can improve community support for the organization, but also can provide a foundation for responding effectively to challenges to the ministry.

Over the past three or four years, he explained, activist groups such as MergerWatch and Catholics for a Free Choice have challenged mergers or other proposed collaborations between Catholic and other-than-Catholic entities on the grounds that such arrangements will deprive the community of certain reproductive services (e.g., abortion,

sterilization).

“People think we’re trying to force our values on others because no one tells them why we’re doing the deal,” said **Sr. Jean deBlois, CSJ, PhD**, CHA’s vice president of mission services. A complicating factor, she said, is that “there are still some people in Catholic healthcare who, when asked what Catholic healthcare means, can only answer in the negative.”

To help members better communicate, last spring CHA released *Telling Your Story: A Communications Resource for Catholic Healthcare*. The book, developed by staff in conjunction with members, provides some

background on CHA focus group results; specific rebuttals to claims by Catholics for a Free Choice; and general tips for communicating with the media, communities, employees, medical staff, and other constituents. (The complete text is available to members on CHA’s Web site, www.chausa.org.)

CHA’s focus groups, conducted in three cities last fall, found “a reservoir of goodwill for Catholic healthcare,” said Bresch. “But the reservoir isn’t as full as we would like it to be. By communicating effectively, you can fill it up again.”

Bresch and Sr. deBlois offered the following advice:

▶ When you’re involved in a collaborative effort with an other-than-Catholic entity, clearly and repeatedly communicate the reasons for the change (e.g., because the community can’t sustain two hospitals).

▶ Ensure that the people responsible for conveying the organization’s image—executives, communicators, board, and others—have an appropriate and deep understanding of what the organization stands for and can explain it in terms that are understandable to the public. For example, Sr. deBlois said, Catholic healthcare organizations should communicate that they are “part of something bigger”—that their actions are rooted in Gospel values and grounded in respect for the human person.

▶ Focus on the richness of the ministry, such as its attention to matters of justice, care for the poor, holistic approach to healing, and commitment to community benefit. “For example, because we value human dignity, we will not let anyone die in unrelieved pain,” she said.

▶ Ensure that all persons in the organization know its mission, values, and heritage and, more important (and much more difficult), that they express that understanding in action. “Our actions have to express who we are or we won’t be able to make our case,” said Sr. deBlois.

▶ Be aggressive and direct in countering misleading or false information with data of your own. “The press is always looking for the story ‘Man bites dog,’” said Bresch. “Our good works and values are not news, but challenges to misrepresentations are. So we’ve got to be aggressive about telling our story.”

Preserve Identity through Shared Values

In Other-Than-Catholic Partnerships, Influence May Not Be Enough

The concept of “influence” in other-than-Catholic affiliations has been a dominant theme over the past five years, but **Rev. Dennis Brodeur, PhD**, believes moral persuasion is not enough to sustain Catholic values in healthcare. “If you don’t have power and control in some areas, you’re going to lose them,” he said.

Fr. Brodeur, who is senior vice president, stewardship, SSM Health Care, St. Louis, described the need to understand and preserve Catholic identity, without becoming so proprietary as to think those values are the exclusive domain of Catholic healthcare. He identified the hallmarks of Catholic identity, along with Church teachings, as:

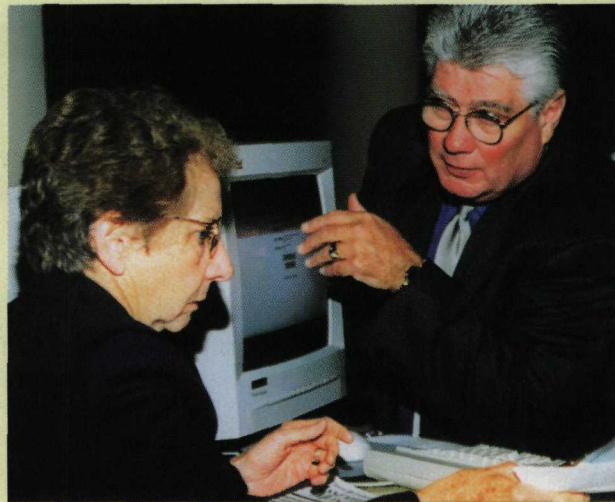
- ▶ An ecclesial connection
- ▶ Canon law obligations
- ▶ A ministry focus
- ▶ A dedication to service to the poor
- ▶ A commitment to advocacy for a better system
- ▶ An emphasis on the mind, body, spirit connection
- ▶ A concern for the common good
- ▶ A basis in the community

Many of the values that characterize Catholic healthcare—such as spirituality, quality improvement, a sense of service, and working in the community—are widely held throughout the entire healthcare sector, he said.

One challenge for Catholic healthcare organizations is learning to translate the Catholic stories “so that they are not theologically dependent, but are reliably told,” he said. The minute negotiations begin, the parties involved should start finding common language and sharing stories.

“The point,” he said, “is to find stories in com-

mon and tell them back and forth until they can be built into rituals.” Negotiating change for a new generation will come about through development of human resource policies, customer focus and service, work place design, culture building, and leadership. Developing outcome measurements in these areas “is where the rubber meets the road.”



Advocacy from Orlando CHA's advocacy staff, including Jack Bresch (pictured), briefed assembly-goers on critical topics and helped them send letters to Capitol Hill on three issues: expanding healthcare coverage, increasing reimbursement for the outpatient prospective payment system, and protecting Catholic hospitals and other safety-net providers.

Another area needing more work is Catholic providers' attempts at “grappling with the *Ethical and Religious Directives*” in negotiating with others outside the ministry. People seem to be becoming more adept at avoidance than they are at talking about material cooperation, a view Fr. Brodeur sees as problematic. “Partnership with other-than-Catholic organizations is essential,” he said, “if we want to continue delivery in some sites.” The best situations, he said, are when the partnership is based on a shared community purpose and a commitment to bring out the best of both cultures to create a new, better culture.

What Makes a Catholic Organization Catholic?

CHA's Benchmarking Task Force Is Developing an Assessment Tool That Will Gauge a Catholic Organization's Faithfulness to Mission

What constitutes Catholic identity, especially in an era increasingly characterized by lay sponsorship of the Church's healthcare organizations? This complex question was the subject of a lively breakout session.

“I've been hearing talk about Catholic identity since I started working in Catholic healthcare 37 years ago,” said **Sr. Jean deBlois, CSJ, PhD**, CHA's vice president for mission services. But, she added, in the 1990s market pressures and increased collaboration with non-Catholic organizations have made the question

“If you don't have power and control in some areas, you're going to lose them.”

Rev. Dennis Brodeur, PhD

much more pressing than it used to be.

Regina Clifton, CHA senior associate for mission integration, described the work of CHA's Benchmarking



Regina Clifton

Task Force, which is developing a method that leaders of Catholic healthcare can use to gauge how closely their organizations are hewing to their missions. Clifton listed seven constitutive elements of Catholic identity drawn from the *Ethical and Religious Directives*

for Catholic Health Care Services, statements from Catholic healthcare systems, and CHA's fall 1998 regional meetings of system sponsors and CEOs:

- ▶ Promote and defend human dignity
- ▶ Attend to the whole person
- ▶ Care for the poor
- ▶ Promote the common good
- ▶ Act on behalf of justice
- ▶ Steward resources
- ▶ Act in communion with the Church

CHA associate **Julie Jones** talked about the benchmarking project's three phases: developing measures of Catholic identity, developing an assessment tool, and actually benchmarking performance at Catholic healthcare organizations. The task force hopes to begin benchmarking in July 2000, Jones said.

Cathy Sullivan Clark, vice president, Jennings Ryan & Kolb, Hadley, MA, asked session participants to suggest ways to strengthen the task force's work. One group said that the seven constitutive elements might be more easily communicated if they were illustrated by personal stories. Another group said that poets or professional communicators should be asked to help improve the language involved.

Session participants disagreed when Clark asked whether CHA should work with members to write a "trans-system, trans-congregational" statement. Yes, said one participant: "We need a stronger national voice on Catholic identity. We need it because so many systems and facilities have put out their own statements, and this has caused a lot of confusion." But another argued that it was too soon for such a statement. "We've brought together a lot of material," she said. "We need to refine it now."

Sr. Mary Rose McPhee Receives First Lifetime Achievement Award



Photo by John LaFata

Sr. Mary Rose McPhee, DC

In her 56 years of service to the Catholic health ministry, Sr. Mary Rose McPhee, DC, has sustained a life-long passion for ministering to the poor and underserved. That passion, combined with a legion of significant accomplishments, brought her CHA's first lifetime achievement award.

Sr. McPhee entered her community in 1941, interrupting her nursing studies to become a Daughter of Charity. She has demonstrated service and leadership as a nurse, a hospital administrator, a visitatrix, a CHA board member, and a regional executive. She has served as the CEO of Mary's Help Hospital, San Francisco; DePaul Hospital, St. Louis; Seton Medical Center, Austin, TX; and Hotel Dieu Hospital, New Orleans. During her stint as the first executive of the West Central Region of the Daughters of Charity Health System, she organized a modernization program that centralized purchas-

ing, financial programs, and management services for the seven-hospital region. Today she is executive director of Seton Cove, a not-for-profit interfaith center for spirituality rooted in Judeo-Christian beliefs.

As a mentor to many people in healthcare, she is known as a compassionate, humble executive who lives the Gospel values in her everyday life. In her role as a congregational leader, she was a catalyst for recruiting lay executives to top-level positions and for the development of management skills among many Daughters of Charity. A philosophy of "mission first, people always" characterizes all of her undertakings.

It Is Time to Reorder National Priorities

An Inner Revolution Is Necessary for Justice to Prevail in the New Millennium



"If we allow the love ethic to drive public policy with respect to the development of a comprehensive national healthcare system, we will find a balanced approach that provides quality, affordable health security for everyone."

Coretta Scott King

For justice to flourish in the new millennium, there must be a reordering of national priorities and spending and a revolution within individual hearts, declared **Coretta Scott King** in the Flanagan Lecture.

Healthcare, she said, is an urgent need, the number-one priority of our national security. "There is something wrong with a system that requires telethons for sick people, but always has unlimited funds for military spending. We could provide basic healthcare coverage for half a million people for what taxpayers are going to pay" for a B-2 bomber.

Her vision for a just system would affirm healthcare as a fundamental right. It would be a system that leaves no person behind, even for a catastrophic illness. Any proposal for reform must incorporate three principles: coverage of catastrophic illness, portability, and affordability.

While acknowledging the role of institutions in advancing the healthcare reform agenda, King also called for greater individual responsibility in lifestyle habits, consumer choices, lobbying, and attitudes. She exhorted individuals especially to do more to clean up the "toxic culture"

that predominates today by turning off the television and celebrating those people whose stories give life meaning and purpose.

"Justice is not only about the issues we face in the legal system, it also has to do with what my husband, Martin Luther King Jr., called 'unenforceable obligations,'" she said. Such obligations "are beyond the reach of the laws of society. They concern inner attitudes, genuine person-to-person relations, and expressions of compassion that law books cannot regulate and jails cannot rectify. Such obligations are met by one's commitment to an inner law, written on the heart."

A revolution in hearts, as well as institutions, will be needed for justice to truly prevail, King said. "This involves making a commitment to rigorous self-analysis and self-criticism about the way we treat other people.

"This call for a worldwide fellowship that lifts neighborly concerns beyond one's tribe, race, class, and nation is in reality a call for an all-embracing and unconditional love for all. If we allow the love ethic to drive public policy with respect to the development of a comprehensive national healthcare system, we will find a balanced approach that provides quality, affordable health security for everyone."



Issues and Opinions This year's assembly offered a number of informal networking opportunities, including tabletop discussions during Wednesday's continental breakfast and Leadership Breakfast Forums for groups to discuss topics of special interest.

Take Chances for the Vulnerable, Poet Urges

Catholic Healthcare's Rich Tradition Has Prepared It to Be the Voice of 44 Million Uninsured Americans

CHA members should "take chances" in offering care to the vulnerable, poet-philosopher **John O'Donohue, PhD**, told an assembly general session. The government's failure to provide healthcare coverage for 44 million Americans has left "an enormous empty space" in society, he argued. "CHA's rich tradition should enable it to become the voice of those millions,

to do things that other organizations can't even begin to imagine."

Jesus recognized the vulnerable as the "true priests and priestesses" of the kingdom he wanted to inaugurate, said O'Donohue, the author of several books of poetry and inspirational writing, including *Anam Cara*, a bestseller in his native Ireland. Illness, he said, is among other things "a call" to become a member of that kingdom. It is because Jesus devoted most of his time and energy to ministering to the suffering that the Catholic health ministry puts the patient at the center of its work, O'Donohue said.

Unfortunately, the market has come to dominate healthcare, O'Donohue told the audience.

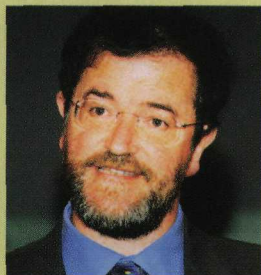
Because market economics always attempts to "reduce creation to commodity," it is incompatible with true care of the ill and the injured. "But because it does this, the market is generating its own opposition—a great spiritual hunger." He urged those involved in Catholic healthcare to become aware of that hunger and learn to address it.

O'Donohue said market economics is symptomatic of "postmodern culture," which values functionalism and utility rather than imagination, individuality, mercy, and justice. "Our society worships those who achieve things," he argued. "Whereas caring is the soul and spirit of justice, postmodern culture tends to be indifferent. There seems to be something closed off—wounded or disappointed—at the heart of that indifference."

Caring is the cure for indifference, O'Donohue said. "Kindness, as Jesus demonstrated, is one of the most powerful forces in the world." But kindness requires the ability to imaginatively enter another person's world. "Imagination is the great servant of justice," said O'Donohue. "Imagination is committed to wholeness; it doesn't like one-sidedness."

But only individuals are capable of imagination, he argued. "Each human being has a duty to become an individual. If you renege on that duty, something within you becomes sad and dies." Healthcare systems, like all other postmodern institutions, are dead until their leaders learn to encourage individuality in staff members.

"Jesus, who was a frontier person always journeying toward the divine, understood better than anyone else the importance of the individual imagination," said O'Donohue. Because they are devoted to Jesus' mission, the leaders of Catholic healthcare must encourage imagination as he did.

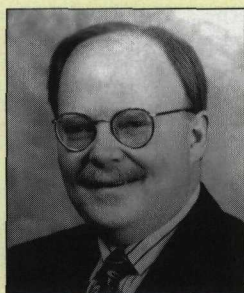
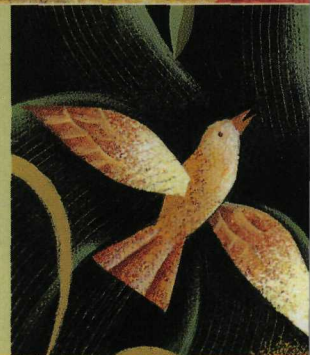


"Each human being has a duty to become an individual. If you renege on that duty, something within you becomes sad and dies."

John O'Donohue, PhD

CHA Board of Trustees

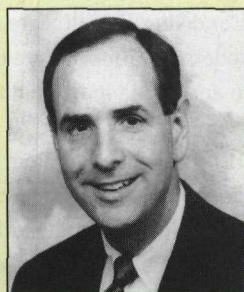
Pictured here are the members of the CHA Board of Trustees for 1999-2000. Members who were elected or reelected at the June 8 membership assembly are marked with an asterisk.



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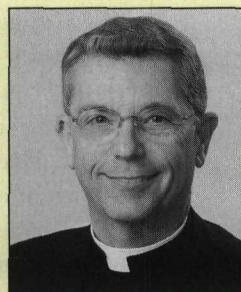
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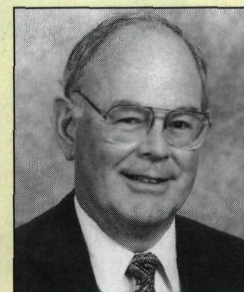
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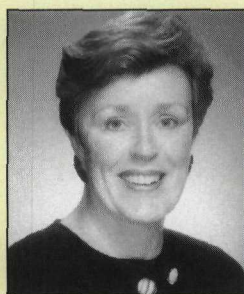
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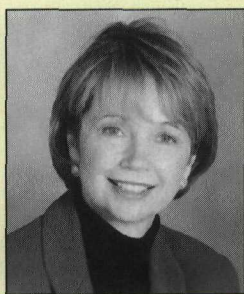
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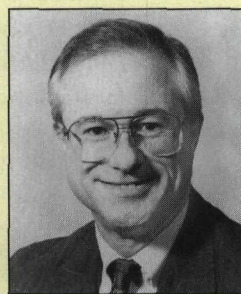
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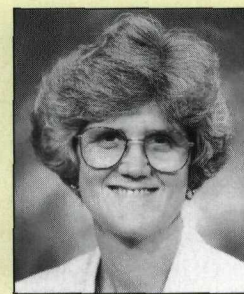
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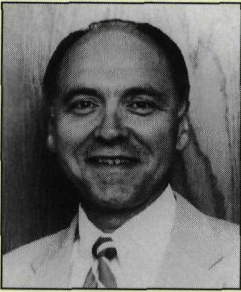
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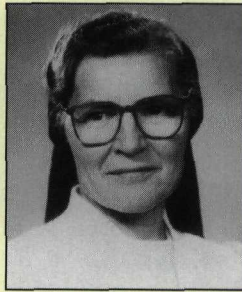
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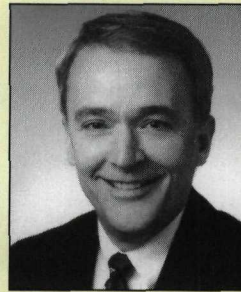
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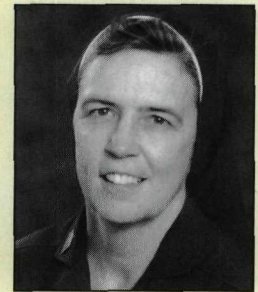
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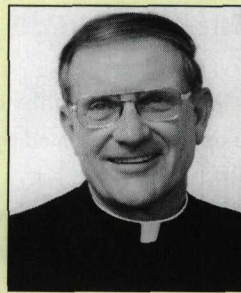
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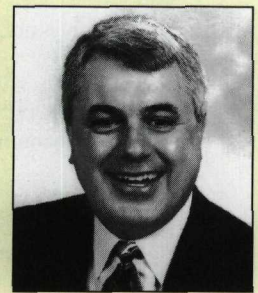
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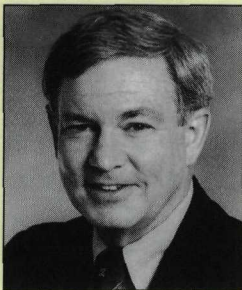
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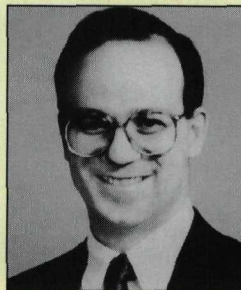
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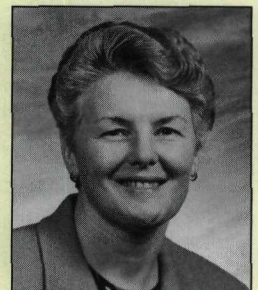
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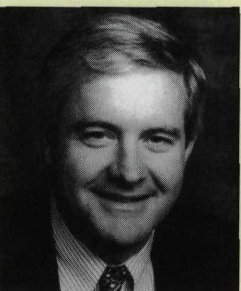
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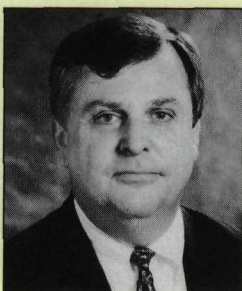
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See you next year at
the 85th Catholic
Health Assembly in
San Francisco
June 11-14, 2000