

WE KNOW WHAT WE VALUE. MEASURING IT IS UP TO US

Early in my career as a mission leader, I can remember the hospital CFO saying to me, “Health care values what it can measure.” At the time I thought he was being too utilitarian. “Surely in Catholic health care,” I thought, “there is an appreciation for things that cannot be measured.” How can you measure the integration of body, mind and spirit? How could you ever measure compassionate care? How could anyone ever hope to get their arms around something as broad as the concept of Catholic identity?



BRIAN SMITH

In my naiveté, I assumed most of a mission leader’s responsibilities fell in areas that did not have metrics — mission integration, ethics, spiritual care, community benefit, for example. But I was wrong.

In the last 10 years, all aspects of health care have been scrutinized for efficiency and effectiveness. Changes in reimbursement from a fee-for-service model to one based on quality outcomes and patient satisfaction has placed many of the “softer” service lines in Catholic health care under the proverbial microscope. For example, spiritual care departments have felt the pressure to demonstrate how the care they provide contributes to overall patient satisfaction. On their patient satisfaction surveys, some Catholic health systems specifically ask patients visited by a hospital chaplain to rate that visit. Yet chaplains in an acute care setting spend much of their time with dying patients, their families and loved ones — individuals who typically will never receive a patient satisfaction survey. So what are we really measuring?

The National Association of Catholic Chaplains (NACC) and CHA’s Pastoral Care Advisory Committee are collaborating to promote research that will objectively demonstrate the value chaplains bring to a hospital’s overall patient experience. In the March-April 2013 issue of *Health Progress*, David Lichter, the NACC’s executive director, cited several reviews of chaplaincy research from the early 1990s to the present. He concludes, “Clinical health care researchers — other than chaplains — are providing the evidence that spiritual issues need to be addressed or health outcomes falter.”¹ He invites chaplains to partner in the effort to provide evidence-based care, in-

cluding the evaluation of current and new practices which will contribute to the research.

On the one hand, research in the area of spiritual care is promising, but the evidence is limited. On the other hand, senior leaders in health care are looking at ways of cost-cutting, and there are other departments and service lines that already have established national benchmarks for efficiency and effectiveness. In the void of no good metrics, sometimes spiritual care departments are being held to productivity numbers recommended by consultants. If one is able to drill down into the numbers, one usually finds the sample cohort is composed of every size hospital imaginable, with faith-based mixed in with for-profit hospitals and rural combined with urban centers. The result compares apples to oranges; but because we have not determined the metrics for effective spiritual care and appropriate staffing numbers, someone else is trying to do it for us.

At this point, it might be helpful to tell a success story. Twenty-five years ago, community benefit was a field without standards of reporting or national metrics. Many people inside and outside the ministry, including policymakers, were asking if nonprofit hospitals were still charitable organizations or if they had morphed into businesses and should be treated as taxable organizations. Hospitals were counting community benefit in vastly different ways, making it difficult to make the case of fulfilling a charitable mission. Some systems were including the uncompensated cost of Medicare and bad debt in their numbers; others were not. Some hospitals were counting donations to local nonprofit organizations’ galas and health fairs as community benefit; others did not, classifying such donations as marketing.

Julie Trocchio, CHA’s senior director of community benefit and continuing care, recalls, “CHA leaders determined that for community benefit to

be taken seriously as evidence of both its commitment to mission and the basis for tax exemption, the field needed standard definitions for what was counted as community benefit and a professional accounting system for reporting. Community benefit professionals from CHA and our partner, VHA Inc., came together to reach consensus on what should count as community benefit. CHA also retained a health care financing expert to design an accounting system that would be consistent with other hospital accounting practices.”

CHA and VHA developed measurement tools, metrics and reporting templates that, within less than a decade, were in use extensively throughout nonprofit hospitals. Several state governments, mandating that community benefit be reported, based their policies on the CHA/VHA materials. In 2008 when the Internal Revenue Service began requiring tax-exempt hospitals to report community benefit, it included the CHA/VHA definitions and accounting system.²

Had we not developed the metrics for reporting community benefit, the federal government would have done it for us — or worse, it might have eliminated the tax-exempt status of not-for-profit hospitals. We valued what we were doing in community benefit, so we came together and developed appropriate measurement.

Can the same be done in other areas of mission integration? Let’s take the question of the effectiveness of senior leadership formation. Brian Yanofchick, my predecessor at CHA, wrote that although “it is clear that the executive leadership programs in place have had a significant personal impact on participants ... among the important questions that remain to be explored:

- Will this personal transformation reported by participants be sustainable?
- Ultimately, what difference will these programs make to the culture of our organizations?
- What is the tipping point in terms of the number of well-formed leaders that will assure the integrity of our Catholic health ministry?
- How should formation be designed and implemented throughout the organization, and when?”³

These questions continue to be discussed by members of CHA’s Ministry Leadership Formation Committee. There is a growing sense that senior leadership formation is essential, but questions about the resources being committed (in both dollars and time) always come up. For

example, what is the measureable difference between leaders who go through an 18-month or a three-year formation program? Some programs require senior leaders to be engaged with a spiritual director or learning coach. Can you measure any difference in behavior or decision-making between the leaders who have spiritual directors and those who do not? And, how do we measure the effectiveness of formation beyond the individual’s own self-assessment? Is it through patient, employee and physician satisfaction scores, or some measure yet to be developed? As one member of CHA’s Ministry Leadership Formation Committee recently stated, “Ultimately, the effectiveness of leadership formation will come down to, did the community we serve get better?”

A few systems are starting to measure the effectiveness of their senior leadership formation programs. In the next few months, CHA and members of the Ministry Leadership Formation Committee will be finalizing a survey instrument to send to approximately 2,500-3,000 senior leaders who have been engaged in advanced leadership formation. The purpose of the survey is to

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see what effect ongoing formation has on leaders’ attitudes and values. Demographic information and the variation in formation approaches (length of program, frequency of meetings, with or without spiritual director, etc.) also will be analyzed.

This research is critical to Catholic health care ministry for a number of reasons. Not only will it answer the practical question about the cost vs. benefit of formation; but more importantly, it will answer the question being posed by sponsors of Catholic health care and many bishops in the United States: How do we know the lay leaders in Catholic health care are preserving the Catholic integrity of the institutions they lead?

How one measures Catholic identity and integrity is related to the question of leadership formation in Catholic health care. Ironically, we are trying simultaneously to articulate what we mean by Catholic identity and how we can measure its

presence or absence. In the previous examples of spiritual care and community benefit, we saw that when there is a void of standards and measurement, other outside entities, with little knowledge of the inner workings of Catholic health care, may try to create them.

This has already been seen by a few Catholic hospitals who have been asked to perform a “mission audit” to assure their Catholic identity. In some of these mission audits that have been conducted, there seems to be a tendency to reduce Catholic identity to observance of a couple of the *Ethical and Religious Directives for Catholic Health Care Services*, with particular focus on Directive 53, which deals with direct sterilizations.

As leaders who value the importance of demonstrating our integrity towards the mission and vision of our sponsors and of “passing” the Catholic identity test of our bishops, it is important we roll up our sleeves and come to a consensus on what we mean by Catholic identity and how to measure it in a way that is not reductionistic, but rather covers the breadth of what Catholic health care entails. This breadth might best be summarized in *A Shared Statement of Identity for the Catholic Health Ministry* and what we, as a ministry of the church, are committed to: 1) Promoting and defending human dignity; 2) Attending to the whole person; 3) Care for poor and vulnerable persons; 4) Promoting the common good; 5) Acting on behalf of justice; 6) Stewarding resources; and 7) Acting in communion with the church.⁴

The good news is there are constructive efforts being made to define and measure Catholic identity in this fuller understanding of the ministry of Catholic health care. One example is the *Catholic Identity Matrix* developed by Veritas Institute at the University of St. Thomas, St. Paul, Minn., in conjunction with Ascension Health, St. Louis. In addition, members of CHA’s Mission Leaders Advisory Committee are committed to keeping this question at the forefront and bringing forth best practices for defining and assessing Catholic identity and integrity.

As all Catholic health systems wrestle with the question of how to measure areas we have never previously measured, it is important to keep in mind the successes we have had along the way. The example of how members of CHA and VHA pooled best practices and developed community benefit definitions and reporting standards reminds us of what we can accomplish when we

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collaborate. This same spirit of cooperation will help us find the measurements we need for other “soft” areas we value in Catholic health care such as spiritual care, leadership formation and Catholic identity. It is my hope CHA members who are wrestling with these same issues will continue to share their ideas, research and findings across the wider ministry. Submitting articles to CHA’s publications, *Health Progress* and *Catholic Health World*, and participating in CHA programs and webinars on these topics, can help advance the discussion until we achieve a solution

My former CFO was right. Health care does measure what it values. But I would add one caveat: In Catholic health care, we know what we value, but we do not always know how to measure it. Isn’t it best that we, who work in these areas we value, be the ones to develop the definitions and standards of measurement rather than be told by individuals outside of Catholic health care, “This is the way you are going to be measured?”

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NOTES

1. David A. Lichter, “Studies Show Spiritual Care Linked to Better Health Outcomes,” *Health Progress* 94, no. 2 (March-April, 2013): 62-66.
2. *A Guide for Planning and Reporting Community Benefit, 2012 Edition*, (St. Louis: The Catholic Health Association of the United States, 2012).
3. Brian Yanofchick, “Leadership Formation: What Difference Is It Making?” *Health Progress* 91, no. 4 (July-August, 2010): 74-76.
4. The Catholic Health Association of the United States, *A Shared Statement of Identity for the Catholic Health Ministry*, www.chausa.org/Pages/Our_Work/Mission/Mission_Resources/A_Shared_Statement_of_Identity/.

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