STATE OF THE MISSION: IDENTITY AS STRATEGY

The State of the Union address is a speech given once a year in which the president of the United States talks about current political and economic issues affecting the country and about his plans for the year ahead. The concept for a State of the Union address is enshrined in Article II, Section 3, Clause I of the Constitution, which states that the president "shall from time to time give to the Congress information of the State of the Union and recommend to their consideration such measures as he shall judge necessary and expedient."

BRIAN SMITH

This last 2018 issue of *Health Progress* is a fitting time to give information on the state of mission in Catholic health care and what the Catholic Health Association and its members see as "necessary and expedient" measures, going forward.

CATHOLIC IDENTITY

The theme of Catholic identity was one of the most prevalent issues for the ministry in 2018. Although those who work in Catholic health care continue to celebrate the fact that we are a ministry of the church, responsible for bringing God's healing love and presence to the world, there are others who oppose and try to undermine our Gospel commission. Some advocacy groups maintain that the Catholic identity of our institutions denies access of care to women, transgender individuals seeking surgery to remove reproductive organs and the dying who may seek assisted suicide. An Aug. 10, 2018 article in the *New York Times* implied that Catholic hospitals in the U.S. hide their Catholic identity from the public.[1]

We do not hide our identity to trick patients into coming to our facilities so we can deny them certain procedures. It is precisely because of our identity as a ministry of the Catholic Church and our Christian emphasis on human dignity that we *lead* with our identity, treat all patients with dignity and deliver holistic care in a manner consistent with our religious beliefs and moral tradition. We may not provide some procedures performed in other health settings, such as elective sterilizations, abortions and assisted suicide, but it is not because we are hiding our identity — it is precisely because we are being true to who we are.[2]

To counter such attacks on Catholic health care, members of CHA are beginning to make identity part of their strategy. Our foundation in Gospel values and Catholic social teaching inspires our workforce to deliver compassionate, quality care. Catholic systems consistently rate higher in quality scores than other nonprofit and investor-owned health care systems.[3]

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Many systems believe it is precisely because of our Catholic identity and rich heritage that we are out-performing others. The excellent quality delivered in our facilities has been to the benefit of health care in the U.S. — something that should be celebrated and not placed under suspicion.

COLLABORATIONS ARE GOOD AND NECESSARY

The trend towards more collaborations among Catholic health systems, ministries and other-than-Catholic partners continued in 2018. There is greater collaboration, dialogue and synergy emerging between members of CHA. Sponsors, CEOs, mission leaders, ethicists, legal counsels, advocacy departments and others within the ministry are becoming increasingly open to sharing ideas, resources and successes.

Sometimes this leads to mergers, as with Bon Secours Health System and Mercy Health, now Bon Secours Mercy Health. Other times, collaborations with ministries like Catholic Charities and Mercy Housing bring resources together to address social determinants of health such as affordable housing, food security, transportation, etc. Sometimes the networking is about bringing a collective voice around important social justice issues like immigration reform, as demonstrated this year by collaboration among Catholic health care, the United States Catholic Conference of Bishops' Committee on Migration, and the Catholic Legal Immigration Network, Inc.

The importance and necessity of partnerships with other-than-Catholic organizations was reaffirmed in June 2018 when the USCCB approved the revision of Part Six of the *Ethical and Religious Directives for Catholic Health Care Services*. The revised Introduction to Part 6 reaffirms that "Catholic health care, in serving the common good has historically worked in collaboration with a variety of non-Catholic partners. ... Collaborative arrangements can be unique and vitally important opportunities for Catholic health care to further its mission of caring for the suffering and sick, in faithful imitation of Christ."[4] Partnerships that advance the common good and avoid material cooperation demonstrate the church needs to be engaged in the world. As CHA's senior director of theology and sponsorship, Fr. Charles Bouchard, OP, STD, likes to say: "We are not a church in isolation. We are a community that is incarnational, willing to take risks of getting a little dirty in order to serve the common good — while at the same time maintaining our Catholic moral tradition."

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In addition, the revisions to Part Six bring clarity to the role of diocesan bishops when health care systems extend across multiple diocesan jurisdictions and the duty of a bishop in which the system's headquarters is located. The latter is to initiate the collaboration of the other bishops affected by collaborations with Catholic or non-Catholic partners.[5] The bishops anticipate mergers and partnerships are here to stay, and they have mapped out a process so that health systems, partners and the local diocesan bishops are in dialogue with each other.

MINISTRY IDENTITY ASSESSMENT BECOMING THE NORM

In 2018, CHA created a common framework for measuring ministerial identity. The framework emerged from a task force that studied several current assessment tools. All use core values grounded in Gospel principles and Catholic social teaching. They all name objective and quantifiable key performance indicators that demonstrate the core values are being expressed and demonstrated in a visible way. Ministerial identity assessment recognizes that identity is an ongoing process and not something we think about only every three years. CHA members are making ministerial identity one of their ongoing quality improvement initiatives.

For those members who do not have an assessment process, the task force developed the CHA Ministry Identity Assessment. Four member facilities piloted the assessment in 2018, and a manual soon will be available. The CHA Ministry Identity Assessment process allows a facility to measure itself against CHA's *Shared Statement of Identity* and seven core commitments. Some pilot

sites chose to use two or three core commitments each year by which to measure their organization; other sites chose to use all seven core commitments at the same time. The process allows for organizations to decide their time frame, number of core commitments and what key performance indicators they will select to determine the maturity of ministry identity within the organization.

The process was piloted in both acute and nonacute care settings and found to work in both. Several member facilities that are Catholic but owned by another nonprofit or for-profit system have expressed interest in using the CHA Ministry Identity Assessment as a means of fulfilling their obligation to the local bishop to routinely assess and report how their organization is demonstrating its Catholic identity. Again, we see how central Catholic identity is to the ministry.

FORMATION REMAINS A PRIORITY

Because of the emphasis on Catholic identity, formation remains a top priority at all levels of the ministry. The 2018-2020 CHA Strategic Plan calls for "expanded ministry formation opportunities for members."[6] To further that objective, CHA added a new position, senior director of ministry formation, and chose Diarmuid Rooney, MS-Psych, MTS, DSocAdmin, to serve in the role.

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Rooney has visited several systems' mission and formation departments to listen to the needs of members and see how CHA can best serve its members in developing additional formation opportunities. A comprehensive formation strategy is emerging. When completed, it will include CHA's shared understanding of what formation is, the key content areas, suggested pedagogy, online resources for delivering formation at various levels of the organization and a description of the expected resulting behaviors of those who participate in formation.

In addition, CHA will help advance the formation and competency development of those who lead formation, so the ministry will have qualified individuals available to expand ministry formation. It is anticipated some type of formation program for formation leaders will be available to CHA members by the end of 2019.

ONBOARDING NEW LEADERS

In July, CHA's Mission Leaders Advisory Committee gathered in St. Louis to look at emerging mission, formation and spiritual care issues. Closely related to the discussion of formation, yet distinct, is the onboarding of senior leaders who are new to Catholic health care. One mission executive said the senior leadership team is composed of "people who are new to Catholic health care and may have come from investor-owned health care or other non-profit businesses. While they have gifts and competencies, they have no understanding of health care as a ministry. Not knowing any better, they will publicly ask questions like: 'Why is formation necessary? What am I supposed to do with a mission leader? Why do we need to use an ethical discernment model when the business case is so evident?' If the senior leaders are questioning what is ministry, mission and formation, how will we ever be able to advance it for others?"

This led to a discussion of how we are recruiting and hiring for "mission fit" as well as how we onboard new executive leaders in their first 90 days. Although new leaders eventually will attend their system's extended senior formation program, the Mission Leaders Advisory Committee felt something more immediate is needed.

Some mentioned that CHA's formation program, *Foundations for Leaders of Catholic Health Care*, at one time was the process used for onboarding new leaders to Catholic health care. Many systems have adapted the program content and paired it with other system onboarding and organizational development materials. But it was pointed out that CHA only offers *Foundations* once a year in an online version, and most systems offer their own version only a couple times a year. Members have asked CHA to renew and redesign the online program so that members can access it in real time and allow for asynchronous learning so that individuals can access and use the program any time. Work is underway on this objective, and

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some of the changes will be piloted in early 2019 when the online program is next offered.

There is still a need to offer a type of Catholic health care "boot camp" in an ongoing manner, so new leaders will have access to this information as soon as they begin their role. Here we are not talking about formation, as much as essential content executive leaders need to comprehend to be successful in their new role and to avoid unintentional damage to the culture. This topic will be discussed further with system mission leaders in February 2019 at the System Mission Leaders Forum.

MISSION LEADER COMPETENCIES EXPANDING

As health care continues to evolve in delivery models and partnerships, mission leaders will need to balance tradition with transformation. Understanding culture, what impacts it and how to shape it during times of rapid change are new skills mission leaders will need to have. Going forward, some of the skills our peers in organizational development possess may be useful for mission leaders to acquire. The Mission Leaders Advisory Committee discussed whether the current CHA Mission Leader Competency Model needs to add this as a new competency or include it within an existing competency, such as the leadership category.[7]

The Mission Leaders Advisory Committee also discussed giving greater clarity to the model's organizational management and personal qualification sections. Some committee members spoke of a "cluster of skills necessary for executive mission leadership that would include strategic planning, business and financial acumen and the ability to adapt as the health care landscape changes."

Those are skills expected of all executive leaders in health care, and they need to be added to the *Mission Leader Competency Model* if the professionalism of the mission leader role is to advance. Newer mission leaders also will need the related developmental and formational resources to prepare them for progressively more responsible positions.

MISSION DEPARTMENTS EVOLVING

Finally, in 2018 we saw a few major systems begin restructuring their mission departments. This was driven by aligning the mission department to broader system organizational changes caused by mergers, acquisitions and restructuring health delivery models from acute to post-acute.

In general, we are seeing fewer hierarchical leadership layers within health care and within mission integration. Whereas 30 years ago, most mission leaders in acute care held the title of vice president, we now see more directors and senior directors at the facility level, vice presidents serving in regional positions and senior or executive vice presidents at the system level. The same changes are occurring in all departments and at all levels of health care.

Several systems are identifying the body of work mission leaders have become experts at leading and therefore should be accountable for. Most system mission departments focus on these core areas: formation, spiritual care, workplace spirituality, ethics, community benefit, church relations and Catholic identity. Some systems also include advocacy and outreach within the mission department.

Although several of these areas have been within the domain of mission integration, the newer models select mission leaders with specific expertise to lead that area for their system or region. In addition, the model builds in accountability through deliverables and metrics that mission leaders and their departments are expected to meet.

This type of accountability mirrors what is expected within health care's clinical, financial and operational departments. As this new requirement for mission accountability develops, CHA will assist its members by sharing ideas and best practices for how mission metrics are being developed and used.

CONCLUSION

The mission of Catholic health care is alive and well. Despite external attacks on Catholic identity

and false claims about Catholic facilities' quality scores, the ministry continues to deliver the highest level of quality care in the United States. Ministry identity is not something we hide, but, rather, proudly invite people to experience.

Our systems attract associates who wish to use their gifts and talents to heal in the manner evidenced in the Gospels. To ensure that this identity remains vibrant, Catholic health care onboards leaders with critical information and offers formation at all levels, so that all who work within the ministry know what is expected. We also measure our ministerial identity in an ongoing manner through objective assessment tools, and we are accountable to our sponsors and local bishops.

Finally, we show that our identity remains vibrant because it is able to live in the tension of tradition and transformation. Whether we are involved in revisions to the *Ethical and Religious Directives for Catholic Health Care Services*, assessing new competencies necessary for those who lead mission and formation or restructuring our systems and departments to better serve patients, residents and communities, Catholic health care in the United States shows it has amazing adaptability and fidelity as a ministry of the church. I invite all of us to lead with our Catholic identity and allow it to drive our strategies.

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NOTES

1. Katie Hafner, "As Catholic Hospitals Expand, So Do Limits on Some Procedures," *New York Times*, Aug. 10, 2018.
2. Catholic Health Association, "Catholic Health Association Responds to New York Times Article, 'As Catholic Hospitals Expand, So Do Limits on Some Procedures,'" news release, Aug. 11, 2018. www.chausa.org/newsroom/news-releases/2018/08/15/catholic-health-association-responds-to-new-york-times-article-as-catholic-hospitals-expand-so-do-limits-on-some-procedures-published-08-11-2018.
3. "Catholic Health Association Responds," news release.
4. United States Conference of Catholic Bishops, "Introduction to Part Six," *Ethical and Religious Directives for Catholic Health Care Services*, 6th ed., (Washington, D.C.: USCCB, 2018).
5. *Ethical and Religious Directives*, Directive 69.
6. Catholic Health Association, "Strategic Plan FY 2018-2020." www.chausa.org/docs/default-source/default-document-library/strategic-roadmap-2018-2020.pdf.
7. Catholic Health Association, *The Mission Leader Competency Model*, (revised 2016). www.chausa.org/docs/default-source/mission/mission-leadership-competency-model_final.pdf?sfvrsn=0.

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