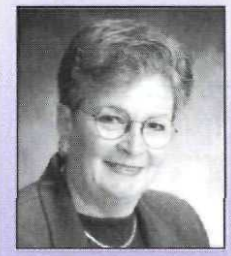
Mission at the Millennium

Catholic Healthcare Systems Are Beginning to Develop Professional Mission Leaders

BY MARY KATHRYN GRANT, PhD



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Although Catholic healthcare has seen many changes in the three decades since the Second Vatican Council, none has been more significant for the ministry than the emergence of the professional mission leader.

The process began in the 1970s when, because sponsoring congregations had fewer members to send into Catholic hospitals as nurses and administrators, they assigned women religious to positions as leaders of mission services, to keep the connection between the Church and the ministry alive. In those days, the mission leader's role, work requirements, and salary often varied from hospital to hospital. There were few opportunities for professional training, such as internships or mentoring programs. Mission leader positions were sometimes held by sisters experienced in healthcare, but frequently one of the congregation's educators or even a former member of its leadership team took the job.

Corporate and Institutional Developments

The early mission leader usually had to define, as well as legitimize, her own position in the organization. Knowledge required for the role ran the gamut from theology to adult development, from pastoral care to education or counseling. As multi-institutional systems began to form in the late 1970s and early 1980s, they established mission leadership positions at the systems' corporate headquarters. Mission leaders at the corporate level were responsible for identifying and training mission leaders at the member facilities.

The title assigned to the office of mission leadership at the corporate level varied from system to system. For example, the Sisters of Mercy Health Corporation had a department of Ministerial Development; the Holy Cross Health System (HCHS) had one for Apostolic Development; and the Mercy Health System–Burlingame, CA, had one for Philosophy Development. Accountability varied with the titles. In some cases, the mission leader was appointed by, and responsible to, the sponsoring congregation; in other cases, the leader, though appointed by the congregation, was responsible both to the congregation and the corporation; in still others, the leader, appointed by the congregation, was responsible only to the corporation; and, in yet others, the leader was both appointed by and responsible to the corporation alone.

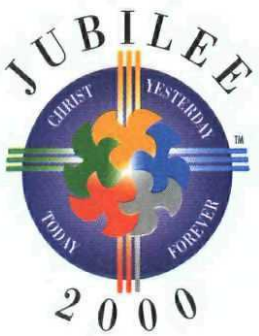
In the early 1980s, organizations such as the Catholic Health Association (CHA) recognized that mission leadership was vital to the ministry's future and began to sponsor conferences on the topic. (CHA also started collecting and analyzing data concerning mission leadership.) By the end of the decade, most Catholic healthcare facilities had implemented some version of the mission leadership role.

Unfortunately, a mission leader's responsibilities were often unclear in those years, and, as a result, some mission leaders lacked legitimacy in their organizations. Those without healthcare experience sometimes reported feeling marginalized. Although mission leaders might be called on to lead prayers, organize retreats, or oversee charity drives, they were rarely able to influence their facilities' decision-making processes. Some were even denied access to those processes. In instances where the CEO was a member of the sponsoring congregation, and considered herself the organization's *real* mission leader, she often perceived the professional mission leader as a threat.

Early mission leaders' contributions to value creation was not always apparent from a strategic or economic point of view. And some mission leaders felt resented by coworkers—especially when, in times of downsizing, the mission leaders' positions were secure.

Links with Human Resources and Pastoral Care

Because many of the early mission leaders came from educational settings, it was natural for them to see their new role as primarily employee orienta-



tion, education, and development. Their involvement in these activities proved to be both a blessing and a dilemma. For organizations that strongly desired to maintain their sponsors' culture and heritage, this reinforcing of their human resources departments was welcome. For others, however, it was problematic: Which department would have ultimate responsibility for developing the workforce—human resources or mission?

The dilemma was exacerbated by the fact that human resources departments, having formerly performed a more narrow personnel function, had only recently come to be valued for their own contributions to corporate strategy. It was natural that, as mission leadership departments appeared alongside human resources departments, those who worked in them would sometimes feel like competitors.

To avoid competition, some systems made human resources part of their mission leadership departments. But that also caused problems. These departments inevitably became involved in strategic planning issues, thus requiring a close alliance with the system's strategic planning department. Such alliances introduced competitive feelings between people in mission leadership and those in strategic planning. In addition, mission leaders often found that while they brought vital skills to the alliance (especially those involved in discerning mission imperative), they did not speak the "language" of planning.

At the facility level, the mission leader often oversaw the pastoral care function. More recently, hospitals have acknowledged the difference between mission services and pastoral care and now often separate the two functions.

The evolution of mission leadership involved significant growing pains.

The evolution of mission leadership, like that of other disciplines, involved significant growing pains on both the organizational and the personal level. In the early days, a typical mission leader led the organization in celebrations, in memorials to the history and legacy of its sponsors, and in prayers and festive events. All these functions are vital to any organizational culture—but they are not sufficient. The mission leader soon discovered the need to learn other skills and "languages"—competencies that would help her balance mission with financial, strategic, and sponsorship objectives. In other words, the mission leader had to become a professional. (See **Box**.)

Developing Necessary Competencies

For some time, Catholic healthcare has been at work identifying the competencies required in a professional mission leader. Since the mid-1980s, CHA has coordinated an annual conference for system mission leaders, as well as smaller educational meetings for those in other settings. Catholic Healthcare Partners, Cincinnati, sponsored a study identifying the competencies needed at the facility level, using the competency assessment methodology developed by Hay McBer, Boston. (See John Larrere and David McClelland, "Leadership for the Catholic Healing Ministry," *Health Progress*, June 1994, pp. 28-33 and 50).

Because different Catholic healthcare organizations have different cultures, they have not agreed

Evolution of the Mission Leader

One veteran mission leader has said that her job seems to have moved "from balloons to balance sheets." The general evolution of the mission leader role might be shown as follows:

Mascot
- Specialized activities
- Awareness building
- Mission statements

Mentor
- Incorporation into human resources
- Behavioral norms for mission performance
- Mission education

Mainstream
- Integration into strategic planning
- Norms for mission integration
- Mission accountability

—Mary Kathryn Grant, PhD

Justice Is the Theme

Dr. Grant's article, the second in a series, explores an issue of major importance for Catholic healthcare in the new millennium.

on the competencies required for mission leadership. However, they generally concur that a mission leader needs "pastoral" qualities—for instance, compassion, approachability, and an ability to listen—combined with business and organizational savvy and negotiation and persuasion skills. And they also agree that although mission will vary from culture to culture, the mission leader's main task is to ensure the integration of mission imperatives into the organization's strategy and plans for the future. (See **Box**.)

Mission Integration and Accountability

Today's healthcare is data driven; everything from market share to patient satisfaction is measured. Mission effectiveness and integration must be measured too, though doing so is a formidable task. One way the mission leader can begin is with the organization's mission statement. Working with others in the organization, the mission leader can use the statement to create mission standards—observable, measurable expressions of the mission's integration and fulfillment. These standards will then become the basis for a process of assessment and development.

Mission leaders can also use surveys, accreditation reports, and quality improvement processes in launching mission assessment initiatives. They can form an interdisciplinary team and ask it to critique the various ways the organization expresses its mission and identify possible areas of improvement. Conducted periodically, these assessments can help renew the organization's sense of mission. More important, they can help identify areas that require new infusions of mission. As with continuous quality improvement interventions, much of the value of a mission effectiveness assessment lies in the process—the assessment is itself an intervention.

New Venues for Mission Leadership

There are two areas in which the professional mission leader may be especially useful in the future.

Corporate Compliance The U.S. government's recent focus on corporate compliance and organizational integrity issues provides healthcare organizations with a rich new area for mission integration. For a Catholic healthcare organization, there is no better place to root a compliance initiative than in fidelity to mission. As law-abiding as most employees of such organizations are, they tend to be even more deeply motivated by a sense of mission. HCHS's mission statement, for example, pledges the system to:

- Faithfulness to the spirit of its sponsor, the Congregation of the Sisters of the Holy Cross
- Excellence in the delivery of services
- Empowerment of those affected by those services
- Stewardship of the human, financial, and environmental resources with which the system has been blessed

HCHS has made these pledges the basis of its organizational integrity program.

Integrating Mission and Planning At HCHS, the mission leader's job is to examine new projects in light of the four pledges of the system's mission statement. With each new proposal, the mission leader joins other leaders in analyzing the needs to be served by the project, the resources required, the risks involved (including unanticipated negative fallout), the return on investments, and the effect on the system's assets. The mission leader's contribution to this analysis is a holistic "mission discernment," which examines the human cost of acting or not acting, the likely impact on those to be served, and the probable effect on the local culture.

To fill a role like this, a mission leader must clearly have an understanding of the organization, an ability to ask relevant questions and synthesize apparently disparate bits of information, and, above all, self-assurance. These competencies should complement, rather than overshadow, the more pastoral ones.

Leaders of Catholic healthcare can help legitimize this more strategic role for mission leaders by giving it public support. In addition, they can provide mission leaders with mentoring, coaching, and professional development courses.

Competencies for Academic Programs

In January 1998, mission leaders participating in the Catholic Health Association's (CHA's) annual System Mission Leadership Forum agreed to develop a list of suggested mission competencies that academic institutions might use in their creation of mission leader programs.

CHA convened a work group to develop such a list, which was then presented to participants at the System Mission Leadership Forum of January 1999. The list will be made available for master's and certificate programs at colleges and universities.

For a copy of the list, contact Regina Clifton, senior associate, Mission Integration and Resource Development, Catholic Health Association, St. Louis, MO 63134; 314-253-3562; *e-mail*: rclifto@chausa.org.