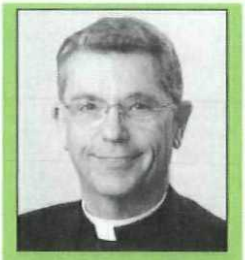
New Report Examines Employee Involvement in Decision Making

BY REV. MICHAEL D. PLACE, STD

One of the major but multifaceted challenges facing the ministry centers on our colleagues who constitute the professional and support staffs that provide Catholic health care. For example, we currently have difficulty achieving a sense of alignment with physicians who are experiencing an "absence of joy"; we are regularly reminded by nurses why an increasing number are seeking the support of organized labor to redress what they consider to be unanswered complaints; and we also hear of the frustration of many others who are the Catholic health care workforce.

Knowledgeable observers of health care delivery in this country are not surprised by these tensions. Health care delivery is in the midst of a profound and rapid realignment. The stresses and strains associated with such a transformation (perhaps even revolution), along with possible unintended adverse consequences flowing from well-intended but failed strategies that seek to respond to these changes, can be the source of frustration, discontent, and anger among health care staff.



Fr. Place is president and chief executive officer, Catholic Health Association, St. Louis.

Any good leader or manager who views our staffs as a rich source of "capital" will be alarmed by this continuous, if not increasing, staff discontent. For those of us in Catholic health care, another reason for alarm exists. As leaders and managers of the great gift we have been entrusted to steward, the healing ministry of Jesus, we believe that the relationships formed between a Catholic health care organization and its employees must reflect the core commitments of our Catholic identity. This commitment involves a deep respect for the inherent dignity of every human person, the intentional promotion of the common good, wise use of the resources given to us by God, and special attention to those around us who are poor and vulnerable.

The task before us then is not *whether,* but *how* we address the current situation. We must ensure that our facilities are marked, as the *Ethical and Religious Directives* say they must be, "by a spirit of mutual respect among care-givers which disposes them to deal with those it serves and their families with the compassion of Christ, sensitive to their vulnerability at a time of special need" (*Ethical and Religious Directives for Catholic Health Care Services,* U.S. Catholic Conference, Washington, DC, 1995, p. 7).

Fortunately we are developing resources that can assist us as we discover and develop our desired response together. Since 1998, CHA has been involved in a project called *Living Our Promises, Acting On Faith,* a program of performance improvement for our ministry. This project first identified a set of organizational behavioral demonstrations of fidelity to the *Ethical and Religious Directives,* one definitive expression of an organization's Catholic identity. The project gathered baseline data about these demonstrations from the acute care and long-term care facility sectors of CHA's membership. In acute care, the baseline data formed a comparative database that has been used to spotlight successful practices (see the June 2000 report, "Year One: Baseline Data and Observations"). This work led to our ministry's first collaborative performance improvement project in enacting Catholic identity.

Acknowledging that ours is a ministry of people in service to others, this first project concentrated on the all-important human resources of Catholic health care. The collaborative project focused on employees' satisfaction with their involvement in decision making within the ministry's acute care organizations. (Building on the 2001 comparative data from long-term care facilities, CHA will engage in performance improvement projects to highlight successful practices in these facili-

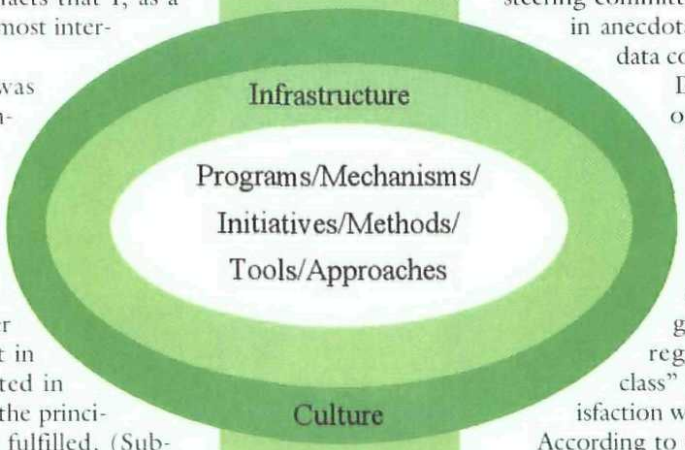
Illustration by José Ortega

ties.) The full report on the results of this critically important effort, "Performance Improvement: Employee Involvement in Decision Making," was released at our annual assembly in June and has been mailed to members. (The report is also available online at www.chausa.org.)

Highlights of the Report

To encourage you to read the full study, I would like to give a snapshot of the facts that I, as a health care leader, found to be most interesting.

The premise of the study was simple. One critical, if not essential, contributor to a positive workplace environment—one marked by a sense of mutual respect—is employee satisfaction with their involvement in decision making. Such satisfaction would also indicate whether a critical Catholic value present in papal social teaching and rooted in the justice norms of Hebrews—the principle of subsidiarity—was being fulfilled. (Subsidiarity dictates that those who are affected by a decision should have a voice in decision making.)



At the conclusion of the initial phase of data gathering, the collaborative partners identified what they considered to be five "drivers" of employee satisfaction in decision making. Drivers are organizational behaviors or infrastructure that support or result in the desired outcome.

Alignment of Expectations and Tools Organizations that align expectations for employees and managers with relevant training, necessary tools, vehicles to enable performance, clear performance measures, appropriate accountability, and follow-up that "closes the loop" achieved higher levels of employee satisfaction with their involvement in decision making.

Communications Frequent communications that use multiple media and styles, repeat key messages, and share meaningful, strategic information with employees contribute to employees' satisfaction.

Culture of Evaluation Some organizations demonstrate a more comprehensive practice of evaluation, measuring the effectiveness of factors ranging from management and leadership style to employee communication vehicles. An organizational culture of regular evaluation of effectiveness—typically informing continuous improvement efforts—also correlated with employee satisfaction scores.

Involvement beyond Project Teams and Standing Committees Two participating facilities with high scores in employee satisfaction with involvement in decision making—Providence Hospital, Washington, DC, and St. Joseph's Regional Medical Center, Ponca City, OK—have implemented processes for meaningful employee input into organizational strategy and work life. Data collected from the other participant facilities also support this driver of employee satisfaction.

Leadership Less quantified in the responses to the data guides, the importance of the leader in facilitating employee satisfaction with involvement in decision making was frequently mentioned by steering committee members in discussions and in anecdotal information supplied during data collection.

During the data gathering period, CHA staff and the consultant for this project, Robert Gift, undertook a search of current business, management, and human resources literature and professional organizations' resources to gather additional learning regarding practices of "best in class" organizations in employee satisfaction with involvement.

According to that research, which is presented in the successful practices section of the report "Performance Improvement Collaborative," another set of drivers of organizational success in creating employee satisfaction are:

- Employee security
- Selective hiring
- Self-directed teams and decentralized decision making
- Compensation
- Extensive training
- Reduced status distinctions
- Extensive sharing of financial and performance information

The entire process yielded several key findings and a number of successful practices that can be adopted and adapted for use in Catholic health care organizations across the country. The research was not, however, successful at drawing a direct "line of sight" correlation between any one practice and higher employee satisfaction with involvement in decision making. Satisfaction appears to be the effect of many factors, such as organizational culture, leadership behavior, and systemic alignment. Respondents who described their organizations' actions that lead to high levels of employee satisfaction with involvement in decisions referred to "putting it all together" and "everything we do." Creating a satisfied, involved community of employees is a synthetic act, as much art as science.

In commenting on this synthetic dimension at a recent meeting of CHA's Internal Management Council, Regina Clifton, vice president for sponsor-

Continued on page 23

canonically own its apostolate. The reserved powers fix and focus the ownership of the health care institution in the canonical juridic person.

The Great Challenge

When Catholic hospitals were founded, there was a *fusion* between the hospitals and their founders. Then, in the 1960s and 1970s, a *distinction* was made between the founders and their hospitals, largely because of the "McGrath thesis." In the 1980s and 1990s the dominant trend was the *separation* of the hospitals from their founders. Catholic hospitals, most of which were a phenomenon brought into existence by institutes of women religious, are today witnessing the evaporation of such congregations from institutional Catholic health care.

Thus the great canonical challenge and question is: Who will become the next generation of Catholic health care owners? Sponsorship is now slowly shifting from religious institutes to lay groups. How will the eventual ownership change be managed?

The future of the Catholic health care ministry in the United States appears bright. Now is the time to ensure that the bright promise becomes reality. □

NOTES

1. Jordan Hite, *A Primer on Public and Private Juridic Persons: Applications to the Catholic Health Care Ministry*, Catholic Health Association, St. Louis, 2000, p. 37.
2. John J. McGrath, *Catholic Institutions in the United States: Canonical and Civil Law Status*, Catholic University Press, Washington, DC, 1968.
3. See Paul C. Reinert, "The Role of Religious in Management," *Hospital Progress*, September 1967, pp. 59-61, 96-100. Fr. Reinert, a Jesuit, was then the president of Saint Louis University. In this article, adapted from a speech he had given two months earlier to the annual CHA assembly, Fr. Reinert essentially endorsed Fr. McGrath's position in the debate. Fr. McGrath himself addressed the 1968 CHA assembly. (*Hospital Progress* was *Health Progress*'s previous name; CHA was then the Catholic Hospital Association.)

   For further discussion of the "McGrath thesis," see Alice Gallin, *Independence and the New Partnership in Catholic Higher Education*, Notre Dame University Press, South Bend, IN, 1996, and *Negotiating Identity: Catholic Higher Education since 1960*, Notre Dame University Press, South Bend, IN, 2000; William W. Bassett, "The American Civil Corporation, the 'Incorporation Movement,' and the Canon Law of the Catholic Church," *Journal of College and University Law*, Spring 1999, pp. 721-750; and Robert T. Kennedy, "McGrath, Maida, Michiels: Introduction to a Study of the Canonical and Civil Law Status of Church-Related Institutions in the United States," *Jurist*, vol. 50, pp. 351-401, especially 351-368.
4. Adam Maida, "Identity of the Catholic Health Facility," *Hospital Progress*, February 1974, p. 65.
5. Paul Boyle, "Sponsorship: Canonical and Social Obligations," *Hospital Progress*, January 1975, pp. 54-56.
6. Michael Place, "Elements of Theological Foundations of Sponsorship," *Health Progress*, November-December 2000, p. 9.
7. Place, p. 10.
8. Catholic Health Association, *The Search for Identity: Canonical Sponsorship of Catholic Health Care*, St. Louis, 1993, p. 81.
9. Canon 298, sec. 1, could serve as a root for the first reserved power ("establish the philosophy"). Canon 94 would anchor the second ("amend the charter"). The canons concerning administrators (e.g., cc. 492-494; 532; 562; 636; 638; 1232, sec. 2; 1279, and 1282-1289) appear to anchor the third ("approve the board"). Reserved powers four ("sell real estate") and five ("dissolve the corporation") seem to be rooted in canons 1290-1298 and canons 121-123 and 320 respectively.

   Rev. Francis Morrisey, OMI, JCD, PhD, a well-known canonist (see his article, pp. 28-31, 51 of this issue), lists eight reserved powers, including those to establish subsidiary corporations, designate the sponsored organization's the chief executive officer and some or all of its board of trustees, and appoint its auditor. See Francis Morrisey, "Basic Concepts and Principles," in Lawrence DiNardo, Kevin E. McKenna, and Joseph W. Pokusa, eds., *Church Finance Handbook*, Canon Law Society of America, Washington, DC, 1999, pp. 3-15, especially p. 14. Fr. Morrisey holds that "the notion of reservation is found in canon 87, sec. 1, and in other canons throughout the code." However, canons 94 and 1279, sec. 1, would seem to provide a firmer grounding in issues concerning the ecclesiastical goods of civilly incorporated apostolates.

EMPLOYEE SATISFACTION

Continued from page 7

ship and mission services at CHA (the senior staff person responsible for this project), asked her colleagues to draw three concentric circles. She asked them to write *action* on the inside circle, *infrastructure* in the second circle, and *culture* in the outside circle (see illustration on p. 7). She then pointed out that both the data gathering and the external research associated with this study had shown that the establishment of an organizational vision of promoting the dignity of the workforce through, for example, promoting satisfaction with its involvement in decision making, could not be achieved without creating specific and measurable strategies. Over time the successful implementation of such strategies is what creates the desired culture of worker satisfaction. The important part of the study, then, is in what each of our organizations can learn from the drivers that surfaced. Some organizations may find that some drivers have no particular relevance for them; no organization should simply adopt a driver without first adapting to its needs. In general, though, an organization that has no successful strategies will have a weak or low level of worker satisfaction. Although the good news of our study is that Catholic health care is long on vision, the bad news is that, in general, it is short on effective strategies for promoting worker satisfaction.

As I write this, I do so acutely aware of the very real impediments to our achieving what we would like to accomplish. My own experience, however, has taught me that the critical difference is in the amount of time dedicated to establishing, implementing, and evaluating potential strategies. As one wise colleague told me, "if you [CEO and senior executives] put as much energy into staff issues as product issues, you could change an organization's culture." Another colleague put this belief a bit differently by suggesting that we have a responsibility to minister not just to our patients, but also to our coworkers. Our colleagues are the subjects of a ministry that will be only words, not a reality, without effective mediating structures. □

JOURNAL OF THE CATHOLIC HEALTH ASSOCIATION OF THE UNITED STATES www.chausa.org

HEALTH PROGRESS®

Reprinted from *Health Progress*, July-August 2001