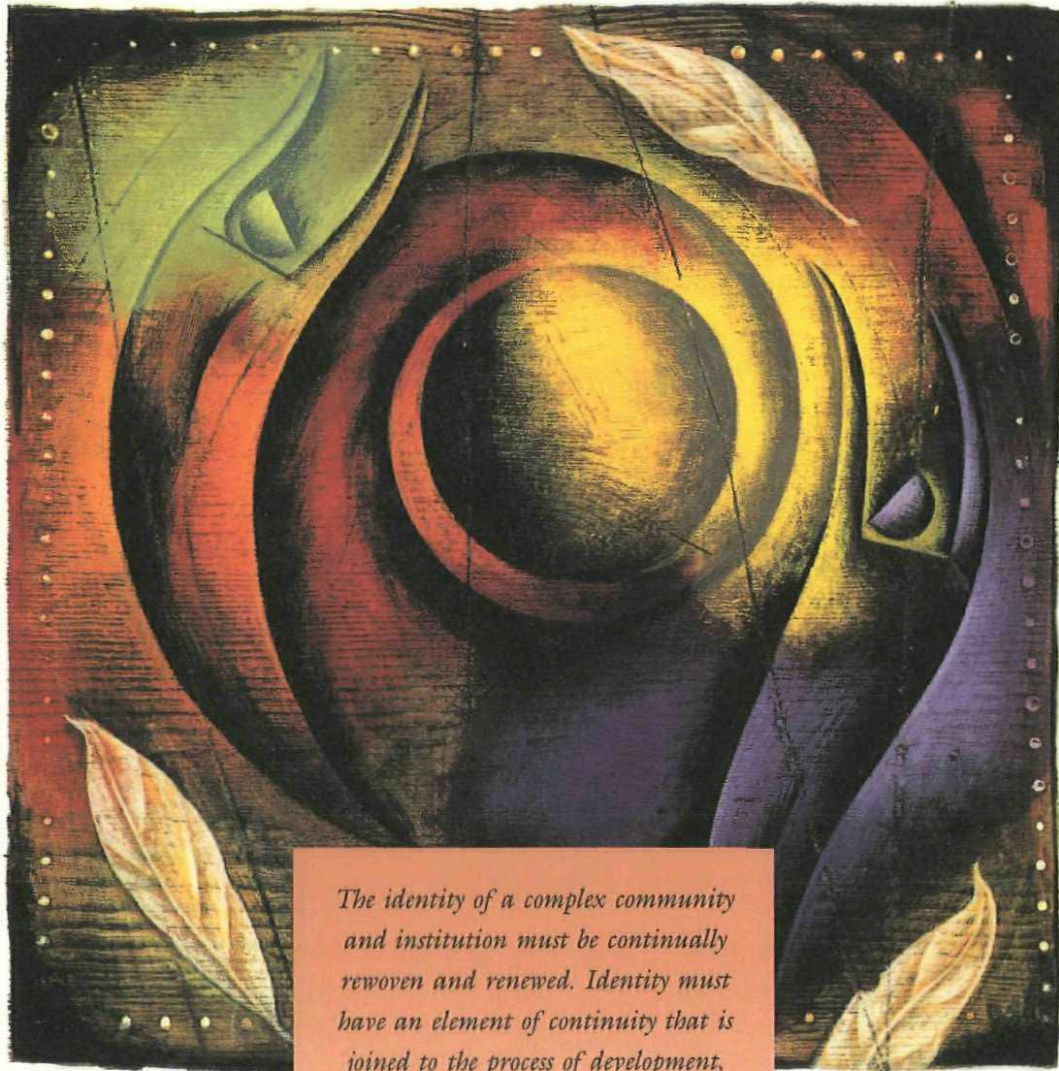


REFOUNDING
The Ministry

LEADERSHIP IN AN ERA OF PROFOUND CHANGE



Nicholas Wilton

The identity of a complex community and institution must be continually rewoven and renewed. Identity must have an element of continuity that is joined to the process of development, deeper understanding, expanding our sense of what our identity is—refashioning it in light of questions that come to us precisely from the rational, secular, pluralistic context in which we function.

Rev. J. Bryan Hehir

The 80th Catholic Health Assembly
June 4-7, 1995

THE TENSION WITHIN THE CATHOLIC healthcare ministry is greater now than at any time in history, as Catholic healthcare institutions strive to fulfill dual roles. "When you try to be both an actor and an advocate—to represent both effective, efficient action and the vision and the voice of the prophets—you have introduced significant tension," said Rev. J. Bryan Hehir, ThD, a Harvard Divinity School professor.

Like many other speakers at the 80th Annual Catholic Health Assembly, Fr. Hehir tackled the tough issues of survival in these times of turmoil. "For actors who must survive, pervasive institutional presence is usually worth something," Fr. Hehir said. "But actors who fulfill a ministry cannot survive at just any cost." The broader questions, he continued, are the place they hold in the system, who they think they are, and what they think they are supposed to be.

These mission-related questions formed the backdrop for an assembly that touched on numerous critical healthcare issues, from ethics to integrated delivery. Almost 1,200 Catholic healthcare leaders attended.

THE CHURCH IN THE WORLD

Fr. Hehir traced the tension present in today's ministry to the Second Vatican Council. The Vatican II document *Gaudium et Spes* posited that the Church is to be in the world, but not of it, Fr. Hehir said. The Church *wants* to be tested, as both actor and advocate, and does this by living where the decisions are made. Fr. Hehir characterized the posture of Vatican II as "confident modesty"—that is, the Church believes it has something to learn from the world, as well as something to teach it. Thus Catholic healthcare is a ministry of both collaboration and criticism, he said. And we are faced with choices all the time of where we can collaborate and how far we can go. These are tactical choices but never purely tactical.

Sr. Jean deBlois, CSJ, PhD, echoed Fr. Hehir's concern about the present, saying that "the relative security of our past is gone." Sr. deBlois, the Catholic Health Association's senior associate for ethics, said Catholic healthcare could allow itself to be homogenized into the broader system. But, she suggested, there are compelling reasons not to do that. "We are the Church. We are the people of God, faith based and value driven," she said. "We can't retreat from the

world; we must be immersed in the world because that's who we are."

AN INSTITUTIONAL PRESENCE

Because Jesus' mission was to bring radical healing to the world, the health ministry is essential to who we are as Church, she said. Fidelity to Jesus, Sr. deBlois continued, mandates an identifiable Catholic presence. Maintaining an organizationally based ministry is critical, she suggested, so "we in ministry have some power to exert as we seek to serve the broader reality of which we are a part."

Fr. Hehir pointed out that Catholic institutions represent the largest groups of not-for-profit healthcare providers, private educational institutions, and social service agencies in the country. This presence is important in shaping, directing, influencing, and elevating a complex industrial democracy, he said. In the 1990s—a time of exploding social problems and declining public resources and will to address those problems—institutional presence is more important than ever, he said.

Catholic healthcare institutions are there "at the critical points where life can be injured or fostered," Fr. Hehir continued. When questions come up about what to do about children, AIDS, and other difficult choices, "we are already there," he said. "The question is how we understand who we are at those strategic points and how we marshal limited resources, often under institutional pressures placed on us by society."

Sr. deBlois suggested that Catholic healthcare must confront the barriers that stand in the way of the realization of God's reign, just as Jesus confronted attitudes and beliefs contrary to God's reign at the same time he was curing. For example, in laying his hands on the leper, who was an "impure" outcast from society, Jesus not only healed him but, more profoundly, restored him to community. Jesus' action teaches that the reign of God is inclusive, excluding no one, she said.

In challenging barriers to God's reign, Catholic providers must address the causes of sickness at the personal, institutional, and social level, Sr. deBlois continued. Not doing abortions because we revere life "is only a piece of what we are about," she declared. We must be vigorously involved in addressing the causes of abortion, such as the breakdown of the family, violence, and poverty. "We must speak with one voice, the voice of Jesus in the



"When you try to be both an actor and an advocate—to represent both effective, efficient action and the vision and the voice of the prophets—you have introduced significant tension."

REV. J. BRYAN HEHIR

world today," to change the social conditions that cause poverty and "embrace the possibilities for true health by being both prophet and witness." Being witness is the difficult part, she said. "It means healing ourselves—our congregations and organizations—so we can heal others."

REFOUNDING THE MINISTRY

In introducing the assembly's theme, anthropologist Rev. Gerald A. Arbuckle, SM, PhD, said that Catholic health-

care must reinvent "radical new ways" to bring healing to people in need. The creativity needed for such reinvention will come from rediscovering the "founding myth" of Catholic healthcare, he said.

Fr. Arbuckle, who is a director of the Refounding and Pastoral Development Unit of the Catholic Theological Union, Sydney, Australia, said that Catholic health ministries are currently in chaos. In human experience, "chaos—the radical breakdown of the predictable—can be a most positive experience personally and organizationally." This



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Sr. JEAN DEBLOIS, CSJ

ST. MARY'S REFOUNDS AND REBOUNDS



Richard Mark

The remarkable re-founding of St. Mary's Hospital, East St. Louis, IL, begun in the 1970s, continues today despite overwhelming obstacles. Attempting to serve the poor in a very poor city that was abandoned by industry

and suffering from declining state and federal support and discouraging prospects, St. Mary's leaders accepted the challenge to untie the chain of poverty that was gripping the institution.

Sr. Kathleen Quinn, PHJC, chair of Ancilla Systems board, Hobart, IN, said St. Mary's declined overtures to move to Collinsville, IL, and elected to remain in East St. Louis "to keep the mission that is important to people alive."

Charles E. Windsor, past president, and Richard Mark, president/CEO, in turn recounted the hospital's rebirth. Their plan rested on four goals: (1) provision of personalized, accessible, coordinated, and cost-effective care, (2) a supportive community willing to address basic human needs, (3) an educated public, and (4) an appropriate mix of health professionals.

Mark said the challenge was how to continue the mission when the hospital was losing approximately \$600,000 a month. Through consultations with department heads, he said, the hospital was able to reduce bed capacity from 176 licensed beds to 105 and to lay off 120 full-time employees, for a

savings of \$1.9 million. Renegotiation of contracts and the work of a value analysis team that cut non-salary expenses created additional savings.

St. Mary's then began an internal and external communications program to inform employees and the community of the hospital's deep financial crisis. St. Mary's status as the city's largest private employer ensured widespread press coverage, Mark said.

Mark also began advocating with the state for an increase in Medicaid reimbursement. He convinced the state to allocate a \$5 increase in fines for motor vehicle violations to state trauma centers such as St. Mary's. That move raised \$400,000 in one year, he reported.

Continuing the outreach efforts, Windsor visited more than 100 church and community groups and invited them to use St. Mary's for their meetings. Leasing office space to the Visiting Nurse Association, a hospice, and other groups netted additional revenue. Aggressive physician recruitment efforts and the signing of a managed care contract with public employers such as the county and city governments, the fire district, and the school board made St. Mary's a major player once again, Mark said.

St. Mary's, in cooperation with the East St. Louis Community Health Task Force, is now engaged in a health and wellness outreach program to isolated neighborhoods that is designed, Mark said, "to take our services back to the neighborhoods."

—Robert J. Stephens



"Refounding is the return to the sacred time of the founding experience of one's culture. By locking in on the energy of the founding story, we can be moved to take radical creative steps to apply the founding experience to today's most urgent needs."

REV. GERALD A.
ARBUCKLE, SM

experience of chaos seems to predispose persons and groups to "reidentify, purify, and reown this founding experience," he said. (See Fr. Arbuckle's article, "Culture, Chaos, and Refounding," *Health Progress*, March 1995, pp. 25-29, 48.)

"Refounding," Fr. Arbuckle explained, is "the return to the sacred time of the founding experience of one's culture. By locking in on the energy of the founding story, we can be moved to take radical creative steps to apply the founding experience to today's most urgent needs."

The refounding process, for those in Catholic healthcare, requires that we "acknowledge our own personal need for refounding in Christ," Fr. Arbuckle said. Speaking via videotape, business consultant Margaret J. Wheatley, EdD, told the audience that refounding "isn't something that one does just for spiritual health. This, in fact, leads to economic health, and given where we are with these great business pressures in all of healthcare, this is the way to a much higher level of organizational performance." Wheatley is president of Berkana Institute, Provo, UT.

BUSINESS LEVERAGE

Like refounding, mission can give a healthcare provider business leverage as well as a sense of direction, Kevin V. Sexton told assembly-goers. "If you have programs people demand, insurers are afraid to leave you out," he said. "And the programs people demand will flow from a provider's mission."

Sexton, senior vice president of Lewin/VHI, was formerly president of MetroHealth Medical Center, Cleveland. At that time, in the late 1980s, 1,000-bed MetroHealth "was in trouble and looking for a survival strategy," he said.

The strategy evolved over time, Sexton said, but it was based from the start on MetroHealth's mission: "to guarantee mainstream healthcare for everyone" in its service area. That mission turned out to be good business as well, despite the great number of poor people in its area. MetroHealth's high-quality healthcare programs—particularly its obstetrics department and trauma center—proved attractive to area residents, Sexton said. The medical center's popularity, in turn, brought it contracts with managed care companies. "It's the only thing that motivates them," he said.

Since launching its mission-based strategy, MetroHealth has been able to double

its spending on care of the poor and children while increasing revenue, he said.

Sexton urged Catholic providers to similarly base their care on mission. He stressed mission's practical aspects. "Mission measures options," he said. "It motivates people. And it moves them to take action."

A REFOUNDING EXPERIENCE

Another mission-linked success story was described by Tom Chappell, head of Tom's of Maine personal care product company. Finding that "success had become an empty experience," Chappell entered Harvard Divinity School, where a personal transformation became the impetus for refounding his company. Chappell convened his board members and asked them to consider, Who are we and what is our purpose? He told them to work from the gut and not from the head. The following principles emerged and formed the basis for the company's mission:

- Human beings and nature have inherent worth and deserve our respect.
- We will make products that are worthwhile.
- We will call upon the various gifts of people in a team setting.
- We will seek financial success, but not at the expense of goodness.

Chappell encouraged assembly participants to embark on a similar revisioning process. "Dig deep for the things people really care about and bring them to the top," he said. "Don't worry if they seem contradictory because those are your expectations."

In the assembly's closing session, poet Maya Angelou inspired Catholic healthcare leaders with a message of refounding and commitment. She reminded them that they touch many lives—that "everybody lives for everybody else." Recalling her uncle, grandmother, and other "heroes and sheroes" who were inspiring role models for her as a "poor, lonely black girl" growing up in rural Arkansas, Angelou sang a refrain: "When it looked like the sun wasn't gonna shine anymore, God put a rainbow in the clouds." For her, these role models were "rainbows in the clouds," and she can still call on them for inspiration and strength at any time. "Your brilliance, your beauty, your intelligence, training, energies, and commitment are so precious," she told the audience, "because each of you is a rainbow."

—Susan K. Hume, with Suzy Farren, Ed Giganti, and Sandy Gilfillan

ETHICS IN AN AGE OF AMBIGUITY

THOSE WHO SEEK THE COMFORT OF black-and-white clarity will not find it in Catholic healthcare ethics today. Ambiguities abound as concepts evolve and Catholic facilities apply the tradition to their particular situation.

The U.S. bishops' recently revised *Ethical and Religious Directives for Catholic Health Care Services (ERD)* are not simply a set of rules that Catholic facilities can follow blindly. "We're going to have to translate these directives in our Catholic healthcare facilities concretely," explained Rev. James F. Keenan, SJ, assistant professor of moral theology, Weston School of Theology, Cambridge, MA. "It will be the practice of Catholic healthcare facilities shaping the understanding of the tradition concretely that will in turn shape the tradition for tomorrow."

THE MEANING OF CATHOLIC IDENTITY

Catholic healthcare identity is visible in facilities' ethos, atmosphere, spirit, and legacy of care, not in the directives themselves, said Fr. Keenan, who helped draft the directives. With recent shifts in that legacy—related to fewer women religious, increasing technology, more non-Catholic professionals in the ministry, and the move to managed care—Catholic identity is not taken for granted as it was in the past. Now, an institution's identity is evident in its ethical code and its relationship with the chancery, the neighborhood, and the community. Fr. Keenan laid out three areas critical to Catholic identity.

Christology

To participate in the life of the tradition, Fr. Keenan said, providers must adopt a Christological mind-set. This means their first responsibility is not to determine what the directives say, what the bishops want, or what patients want. Rather, a Catholic healthcare facility's first responsibility is to find out what in the concrete must be done in serving those in need, as Christ did, Fr. Keenan explained.

Relationality

Fundamental to being like Christ is being respectful of other people, particularly patients, Fr. Keenan said. The biggest difference between the 1994 directives and those of 1975 is a shift from a paternalistic best-interest model (where the physician determines the course of care) to a patient-wishes model. However, this latter model can be accommo-

dated, Fr. Keenan warned, only if it is clearly understood that patient wishes will not be heeded if they contradict the Catholic tradition. "Nevertheless, the ambit in which a patient expresses her or his wishes for the future now is obligatory. We must listen to what the patient wants," for example, in the determination of what constitutes extraordinary means.

Virtue-based Ethics

For the past 200 years, Fr. Keenan explained, Catholic healthcare has depended on a duty-based ethics, where the duties or rules were imposed from the outside. In such cases, Fr. Keenan said, people tend to look for "creative loopholes." In contrast, the virtue-based ethics represented in the new *ERD* is based on "interiority." "We believe that by acting well, my facility and I will become better," he said. For example, physicians can only achieve respect for patients when they have internalized the idea that this is the right way to proceed.

APPLYING THE DIRECTIVES

To help facilities apply the *ERD*, they had to be carefully worded, Fr. Keenan said, since each institution has a different context. "In one way, the directives represent all of the U.S. Catholic healthcare world," he said. "But the descent from a rule or a directive to a particular hospital and finally to a particular patient always requires an appreciation of the situation we are addressing."

The *ERD* are stimuli for understanding the tradition and applying it, Fr. Keenan said. In this endeavor, a healthcare facility might first outline its responsibility to patients and describe who those patients are. Then the facility can look at what similar organizations are doing. The application of the directives can then be seen in such things as a facility's protocol for treating victims of sexual assault or for determining whether to withdraw artificial nutrition and hydration.

ETHICS IN PARTNERSHIPS

The *ERD* and Catholic identity become a critical focus for Catholic healthcare organizations entering into partnership with other providers and organizations. In such situations, facilities can protect their Catholic identity through "ethical integrity."

Ethical integrity in partnerships is "not about ways not to change," said Rev. Dennis Brodeur, PhD, senior vice president of stewardship, SSM Health Care System, St.



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REV. JAMES F. KEENAN, SJ



"Every hour you spend reviewing last month's financial resources and expenditures is one hour you've lost in making a difference in the world tomorrow."

REV. DENNIS BRODEUR

Louis. Integrity requires us to sometimes find new ways of fleshing out values and dealing with the inadequacy of previous formulations of our ethical commitments, even those in the old *ERD*, Brodeur said.

In partnerships ethical issues come out in how partners behave toward one another, Bernita McTernan said. McTernan, who is vice president of mission services, Mercy Healthcare Sacramento, Rancho Cordova, CA, said that one principle which emerges immediately is truth telling. In discussions with potential affiliates, McTernan noted that her system discusses not just values but also the interpretation of those values. For example, for one facility the values of respecting life and human dignity could translate to a pro-life stance, whereas for another facility they could mean being pro-choice. "Organizational and personal style are both critical," she said.

McTernan said that in completing affiliations with non-Catholic hospitals, Mercy Healthcare Sacramento arrived at three different answers to the question, How can a non-Catholic facility become part of a Catholic system? Mercy American River has become Catholic and is totally assimilated into the system, she said. (See "Communication Eases Pains of Acquisition," *Health Progress*, March 1995, pp. 30-33.) Methodist Hospital is remaining non-Catholic and follows the *ERD* and its principles of cooperation. Sierra Nevada Hospital will likewise remain non-Catholic when it joins the system. The CEO had a problem accepting the *ERD*, so together the organizations wrote a "common values" document, divided into sections roughly analogous to the content of the *ERD* and outlining the non-negotiable agreements required before the system can proceed with an affiliation.

McTernan added that in resolving value differences with partners, Mercy looks first at how critical the issue is and whether it can live with the ambiguity. "It's not only that the non-Catholic entity is taking on our values; we're looking at a partnership, and we will be different in a positive way also," she said.

ISSUES IN PARTNERSHIPS

The issues to address in partnerships with others will vary according to who the partner is (see **Box**, p. 29). In partnerships with physicians, for example, Catholic healthcare organizations have to address concerns about faithfulness to the *ERD* in their own facilities, in other care sites, and as they relate to the poor, Fr. Brodeur said. Some physicians may

adhere to many of the directives but fail to assume social responsibility across the continuum of care, he said.

Governance responsibilities are another critical area. "When partners are brought into our setting, there is a grave responsibility to help physicians identify how religiously based nonprofit institutions make a difference in the world that we are serving today and tomorrow," Fr. Brodeur said. Governance or trusteeship is not a matter of hanging on to the founder's charisma or protecting a particular group's interests, but of ensuring the organization makes a difference in the world tomorrow, he added.

"Every hour you spend reviewing last month's financial resources and expenditures is one hour you've lost in making a difference in the world tomorrow," he said. "What makes a difference tomorrow is how the corporation begins to adjust its variable expenditures and office resources in response to the needs of the community." Physicians who want to be on a new network's board just to represent their own interests—however legitimate—probably should be part of a management advisory board instead, he said.

JUSTICE IN MANAGED CARE

Catholic healthcare providers must also pay attention to ethical issues in the development of managed care plans. Lawrence A. Plutko, director of the Office of Theology and Ethics, Providence Health System, Seattle, explained how the system furthers its mission of justice through expansion of health plans to vulnerable populations. Using an inclusive framework of justice, the system asks, "Do managed care plans at least potentially offer the greatest possibility for fuller participation in the vital goods of the human community?" Plutko said. In particular, he asked, do the poor have an opportunity for membership? "This becomes ever more critical absent universal coverage and employer mandates."

Developed in the early 1980s, Providence Health Plans (managed care plans) are owned and operated by the system in its Oregon and Washington facilities. The plans are based on the following clusters of values:

- System values: lowering costs; improving access; enhancing quality; providing comprehensiveness, continuity, and stability
- Relational values: ending marginalization; providing structures of membership, such as inclusiveness and permanence
- Contextual values: advancing the

Catholic faith tradition in contemporary ways; being a catalyst for justice in society; putting forth a spiritual and religious worldview in humanity's search for meaning

"Our core value of justice requires us to be flexible and adapt the richness of our ethical and spiritual traditions to new circumstances," Plutko said. "Indeed, we can greatly influence these vulnerable populations, but we can't dominate them. To do justice in a pluralistic society, to advance participation in a vital social good, requires flexibility and creativity and respect for all values. To get bogged down in a single issue really chokes off the total life of ministry to our communities, and it's a misreading of the Catholic tradition."

Plutko added that the health plans help Providence integrate its values and philosophy of care throughout the system. The plans also allow the system to move beyond the illness model into wellness, primary intervention, and health promotion. Some newer programs, for example, address the needs of young people and families "as they wrestle with the meaning of the gift of sexuality and intimacy; as they plan families, parent for the first time."

END-OF-LIFE ETHICS

One of the most visible applications of Catholic social teaching is in the debate over euthanasia and physician-assisted suicide, where arguments fall along a continuum from death on demand to protection of life at all costs. The life-at-all costs posture is as wrong as death on demand, Sr. Carol Taylor, CSFN, claimed. Sr. Taylor, who is assistant professor of nursing at Georgetown University Medical Center, Washington, DC, noted that the Catholic tradition holds that life is sacred and has intrinsic value, but that death ought to be allowed to happen when the time is right. "Part of our challenge as healthcare professionals is to struggle with people when they have to make that determination," Sr. Taylor said.

Unfortunately, she said, relationships between care givers and patients have often become relics of bygone eras, and the system does not encourage providers to offer options such as hospice and pain control. Instead, the patient's only choice is often a technological fight to the finish. If a technological fix does not work, or the insurer will not pay for the technology, then some providers try to eliminate the problem by offering the patient death as option, she said.

Coverage in the media and even training in some medical schools are leading

both the public and healthcare professionals to believe that physician-assisted suicide is a good choice. Unfortunately, the fears that lead people to consider assisted suicide are often credible threats, she noted.

The human realities that underlie requests for assisted suicide include fears of losing control, of intractable pain and overwhelming suffering, of becoming increasingly dependent, of losing human dignity, of dying alone, and of becoming an economic burden on family, she said. Rather than responding to these fears by assisting in suicide, Sr. Taylor advised, care givers can respond in positive ways that meet patients' needs. For example, "most pain can be relieved safely and effectively, but that's not the message that's out there," she said.

In addition, healthcare providers need to create a "culture of care," where they are trained and accountable for restoring patients' dignity and sense of themselves.

Rev. Jeremiah McCarthy, rector of St. John's Seminary in Camarillo, CA, suggested that Catholic healthcare providers need a "matrix of meaning" to give coherence to their ethical decision making. He said this best takes the form of a narrative that "gives us an account of our origins, teaches us values and rules, and teaches us how to endure the darkness that we cannot banish" (e.g., suffering and death). The Christian story, he said, serves as such a narrative, making it clear that there are limits to our power.

At the same time, however, Catholic providers need to develop a way to talk to people whose values are different. "We need to build an argument based on our intrinsic human dignity—saying that ending one's life through physician-assisted suicide is counter to that dignity," Sr. Taylor said.

Fr. Keenan offered further advice: Since arguments based on the sacredness of life may not work in discussing euthanasia with someone who holds different values, he advised putting it in terms of the common good by asking questions such as, What type of society will we become if euthanasia is an option? How will medical and nursing professions be affected?

Solutions to ethical dilemmas must be consistent with Catholic tradition, but flexibility is also needed in applying the tradition to concrete cases. As Fr. Brodeur warned, "Principles are not always absolute demands. We need some applications of these areas in the market. Reasonable people disagree, so if you want everything to be black and white, you're going to be in trouble."

—Susan K. Hume



"If it's wholeness of being that we're about, are we encouraging and holding ourselves, as leaders in health-care, accountable for that holistic practice?"

Sr. CAROL TAYLOR, CSFN

CURLEY WARNS OF FOR-PROFIT THREAT



"As stewards of Christ's healing ministry, you and I understand that we are not free to compromise the future vitality and validity of this Church ministry."

JOHN E. CURLEY, JR.

In remarks to the nearly 1,200 attendees of the 80th Catholic Health Assembly meeting in Minneapolis, John E. Curley, Jr., CHA's president and CEO, outlined the threat by publicly traded, investor-owned chains to the Catholic health ministry.

BY NOW, YOU KNOW THAT CHA COMMISSIONED historian Christopher Kauffman to write about the accomplishments of the Catholic healthcare ministry in the United States. The Kauffman history, *Ministry and Meaning*, chronicles the journey of a faith-filled and faithful people. In spite of their uncertainties and tribulations, these ministry leaders persisted in bringing a healing Christ to the people and communities they cared for. Their commitments and compassions animated the Church and its corporal works of mercy in their respective areas. Indeed, I believe that they will remind you of yourselves.

Like our forebears, we, too, live in troubling times. And, our uncertainties and tribulations are as threatening to the future of this essential Church ministry as were the ocean crossings, hostile settings, and epidemics and plagues of the past. Today, I wish to briefly comment about one of those threats because of its immediacy.

Investor-owned chains are threatening the future of the Catholic healthcare ministry. These for-profit giants are preying upon Catholic sponsors and systems seeking to purchase Catholic hospitals. Perhaps you have seen or heard their pitch:

- Catholic presence will be guaranteed.
- They will preserve the sponsor's mission and philosophy.
- Pastoral care and mission effectiveness will be continued.
- They will provide charity care.
- The chapel can stay.
- The *Ethical and Religious Directives* will be observed.
- Employment practices will be fair.
- Vast amounts of capital are available to the sponsors.

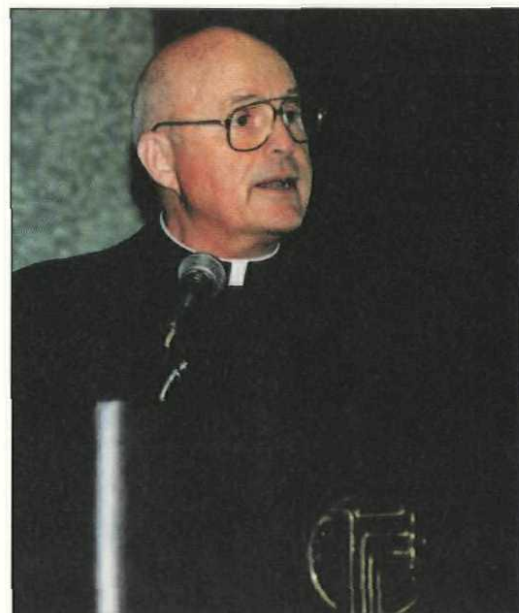
In short, these investor-owned chains appear prepared to pay whatever it takes, promise whatever it takes, do whatever it takes, even "be" whatever it takes to make "a deal." Make no mistake, regardless of how the transaction is described, the investor-owned chains ultimately, and always, intend a buyout. While the surface appeal of large sums of money and eloquent, if unending, promises and concessions to "cookbook Catholicism"

may be a temptation, especially when confronted with today's turbulent marketplace realities, we ultimately know that any offer that seems too good to be true, is too good to be true. As stewards of Christ's healing ministry, you and I understand that we are not free to compromise the future vitality and validity of this Church ministry.

I suppose it is a compliment that investor-owned chains have targeted Catholic hospitals for purchase. They certainly recognize the respectability associated with owning a Catholic hospital. On the other hand, the interest of the for-profit giants could also be construed as an insult. They believe that we can be had.

One favorite ploy of the for-profit giants is to offer huge sums of money to fund foundations. Their suggestion is that the foundation assures a mechanism to continue the mission of the sponsor. The complexities of healthcare suggest a far different reality and probable outcome. In the absence of a significant organizational or institutional presence to leverage the marketplace, there will be no vehicle to call, form, and engage future ministry leaders. In their absence, the sponsor's mission would be lost, and the foundation dream would be an illusion.

The Catholic Health Association is not deceived by the siren call of the investor-



Bp. Joseph Sullivan, DD, of Brooklyn, called on leaders in Catholic healthcare to maintain a penetrating Catholic presence in the United States. He was honored at the fourth annual Concilia Moran Leadership Forum.

owned chains. Simply put, the investor-owned model is not compatible with the Church's mission in healthcare—one can't serve both God and money.

■ First and foremost, our Church ministry sees itself as a sacrament, an unconditional sign of God's compassionate presence; investor-owned chains see themselves as commercial enterprises, like ball-bearing manufacturers.

■ Our Church ministry sees healthcare as an essential human service; investor-owned chains see healthcare as a commodity to be exchanged for a profit.

■ Our Church ministry is driven by the desire to care for people and to serve communities with a preferential option for the poor and vulnerable; investor-owned chains are driven by their need to produce quarterly dividends and a return on equity.

■ Our Church ministry expects its executives to transform Gospel values into healthcare initiatives; investor-owned chains expect their executives to achieve a positive bottom line.

■ Our Church ministry is committed to community accountability; investor-owned chains are accountable to remote shareholders.

■ Our Church ministry respects the sanctity of each human life; investor-owned chains usually provide services that deny the sanctity of life.

■ Our Church ministry uses profitability as the means to address the needs of people; investor-owned chains use healthcare needs as the means to achieve profitability.

The truth is that we do not need the investor-owned chains. We need one another. You deserve to be pleased that there is a marked increase in collaborative ventures within the ministry and with other culturally compatible not-for-profits. More and more, Catholic and other not-for-profit hospitals are looking first to their own rich array of financial and management resources to forge strong partnerships that can serve effectively and compete successfully in local markets. Within the Catholic settings, recent announcements involving a three-system consolidation nationally, and a two-system consolidation on the West Coast, are just two current examples. From our perspective as your national leadership organization, these are signs of how we are working better together.

These examples underscore the urgent need for more collaboration within the ministry. In that sense, they represent a call to



Three programs were honored with the Achievement Citation, the highest honor CHA bestows. The 1995 recipients are the Archbishop's Commission on Community Health, Archdiocese of St. Louis, St. Louis; Domestic Violence Task Force, Sacred Heart Medical Center, Spokane, WA; and Project MotherCare, Hospital of Saint Raphael, New Haven, CT.

action. Consequently, I am delighted to announce a Leadership Invitational Convocation scheduled for October 30-31 near Chicago. Designed to suggest analysis, possibilities, new ideas, priorities, and action strategies for the future, this summit will call ministry leaders to a year-long process to collaborate on the future vitality of the ministry. I am especially privileged to tell you that this initiative will be jointly sponsored by CHA, the National Coalition on Catholic Health Care Ministry, and Consolidated Catholic Health Care. Now that evidences the kind of collaboration we need.

There have always been threats to the future of the ministry. There always will be. On the other hand, there is also the hope and promise that we must bring. As Church leaders, we are individually and collectively entrusted with the future of this essential ministry. It is our commitment and compassion that will animate the instructions of Jesus (Mt 10:6-8): "And as you go, proclaim that the kingdom of heaven is close at hand. Cure the sick, raise the dead, cleanse the lepers, cast out devils."

Christ was not thinking about commodities, profits, or shareholders. Rather, he was thinking about people, healing, and redemption. The hope and promise that we bring is our fidelity, within the Church, to Christ's hope and promise about people, healing, and redemption. □

GOVERNANCE STRUCTURES AND sponsorship roles are changing rapidly with the formation of new types of multi-institutional systems and integrated delivery systems. Responding to pressures to control costs and maintain high-quality services, these systems are focusing on improving the health of the communities they serve. The challenge for boards and sponsors is no longer to ensure a single hospital's viability but to oversee a healthcare organization that is accountable for providing a continuum of health services.

COMMUNITY FOCUS FOR BOARDS

Understanding the community's healthcare needs and developing systems of care that most effectively and efficiently address those needs are the key issues for today's boards, said William Henry, president of Foresight Strategy Associates, Inc., St. Paul, MN. The board must determine how best to use the hospital's resources within that context.

Henry insisted that boards *not* use the hospital's mission as their guide, as they have in the past. Instead, trustees should use the organization's purpose (i.e., why it was created) as a "lens" through which they look at the organization's mission, vision, and strategies in order to make decisions.

A "transforming exercise" for board members, he noted, is to personally interview community leaders. "Ask two questions: What works regarding health in this community? and What do we need?" Henry advised. He described two rural areas in which hospital boards used such information to develop regional care systems.

VISIONARY ROLE FOR SYSTEM BOARDS

Crafting such visionary approaches will be the primary role of governance at the system level, said Joanne Mower, president of the Mower Group, Haddonfield, NJ. System boards, she insisted, must provide disciplined leadership that helps local boards actualize a vision of community-based planning. Boards have an exciting opportunity to "work with the community in writing new standards of health," she said. One hospital she worked with expanded its services after redesigning its governance structure.

The complexities of system governance are growing, said Sr. Karin Dufault, SP,

PhD, chairperson of the board of the Sisters of Providence Health System, Seattle. For example, at a recent meeting that board reviewed 37 collaborative activities going on throughout the system.

Sr. Dufault also said the role of governance is holding the organization's purpose firmly in sight. "Governance plays an essential role in ferreting out the big picture and testing new concepts against core values so that our organizations do not get so caught up in the frenzy of the competitive environment that they lose their moral compass, as well as good business sense."

In this role, "the board must be organically connected with management," she said. She emphasized the board's responsibility for encouraging the organization's leaders and holding them accountable for implementing initiatives that advance the vision.

Carrying out this new vision requires a fundamental shift in trustees' thinking. In 1994 the Providence system designated 10 geographic service areas to bring the components of the continuum together. Each must develop an integrated system to improve the health status of the local population. As a result, Sr. Dufault said, the Providence board is addressing significantly different issues than it did in the past.

"We no longer look at financial data for a single facility but instead evaluate the service area as a whole," Sr. Dufault explained. "We spend much less time reviewing proposals based on the needs of individual facilities and much more time on how the service area is positioning itself through collaborative activities with other community providers, through new models of integration with physicians, and through strategies for contracting with health plans."

Local boards' roles are also changing. The Providence system board has asked local boards to expand their role in quality management, safety, and medical staff credentialing. They are taking on more responsibility in strategic planning, service and program development, financial oversight, and evaluation of leaders.

SPONSORS CALLED TO SHIFT THINKING

Sponsors, too, are pioneering new roles and changing their mind-sets. Mower said sponsors' role is to contribute both a national and local perspective and empower boards "to move in harmony with the new vision."



System boards have an exciting opportunity to "work with the community in writing new standards of health."

JOANNE MOWER

Network with Non-Catholic Partner

The Sisters of Charity Health Care Systems, Inc., Cincinnati, saw a need for its Cincinnati hospital, Good Samaritan, which had no outpatient services, to partner with another area facility to provide a continuum of services. In January 1995 the hospital affiliated with Bethesda Hospital, a religiously based facility with values similar to those of Good Samaritan. The resulting two-hospital network, TriHealth, is sponsored by Bethesda, Inc., and the Sisters of Charity Health Care Systems, Inc. TriHealth's board is made up of five members from each sponsor, and Good Samaritan remains Catholic.

Both hospitals kept their assets and debt, but they have a common bottom line. "This is the only way we can truly work together for the community's interests," explained Sr. Myra James Bradley, SC, Good Samaritan's CEO. "It's as much of a merger as you can have without merging."

New York Catholic Network

In New York City, two hospital sponsors—the Sisters of Charity of St. Vincent de Paul of New York and the Archdiocese of New York—believed it vital for Catholic health-care organizations to partner with one another to continue the ministry in the city's competitive environment. In January 1995 they brought together nine hospitals and nine nursing homes (as well as several other hospitals, nursing homes, and agencies as associate members) in the Catholic Health Care Network of New York. Potentially the network could expand to include non-Catholic healthcare providers and other Catholic institutions, including hospitals in New Jersey, Connecticut, Brooklyn, Queens, and Long Island.

The Catholic Health Care Network of New York is currently operating in a transitional model while it studies possibilities for the final governance structure. Karl P. Adler, MD, president/CEO, St. Vincent's Hospital and Medical Center of New York, is chairperson of the network's hospital/nursing home liaison committee. He favors a strong centralized governance structure with "one bottom line, one voice, one signature."

The central organizational model is the only one that has met with wide-scale success, Adler said. This model provides the optimal ability for network members to share risk in a capitated environment, he noted, and individual institutional approval for every decision is not necessary.

Transfer of Sponsorship

With 69 sisters whose average age was 72, the Grey Nuns (Sisters of Charity of Montreal), St. Joseph Province, Lexington, MA, decided in 1992 that they needed to refound their ministry to prepare for the future. After looking at a dozen options, they decided to transfer sponsorship of their institutions to Covenant Health Systems, Inc., which they had formed in 1983.

As soon as permission is obtained from the Holy See, Covenant will become a public juridic person of pontifical right. While the transfer will have little effect on local boards, Sr. Dorothy Cooper, SGM, provincial superior of the St. Joseph Province, said the major change will be at the Covenant Health Systems board. The system, as a public juridic person, will act on all matters requiring Church approval. The provincial council of the Grey Nuns makes up the corporate membership of Covenant Health Systems and will have power to elect directors, appoint the chairperson of the board, and approve changes to the public juridic person's mission and philosophy statements.

In summing up the hopes for the new sponsorship arrangement, David R. Lincoln, Covenant's president and CEO, seemed to speak for all those trying new governance and sponsorship approaches. These risk takers find courage in three primary goals: to create a new lay model of sponsorship, to ensure continuation of the founders' mission, and to preserve the Catholic health ministry.

—Judy Cassidy



"Governance plays an essential role in ferretting out the big picture and testing new concepts against core values."

Sr. KARIN DUFAULT, SP



Carol Freshley shares her expertise with Rev. Kevin Tripp in accessing CHA's "floor" on the electronic bulletin board, HealthOnline.

PHYSICIANS TRY OUT PARTNERSHIP MODELS

THese have been trying times for American physicians. Once independent professionals who dominated the nation's healthcare system, medical doctors have seen their dominance—indeed even their independence—diminished over the past 25 years by insurance companies, hospital managers, the federal government, and the courts. Today physicians face their toughest challenger, the market. For the first time in its history, the United States possesses more doctors (and especially more specialists) than it needs, at least as U.S. healthcare is currently structured.

Physicians have long struggled to balance their autonomy with the needs of the community. Now they are searching for organizational forms that will help them protect their professional and economic interests.

THE MEDICAL STAFF

As described by William E. Jacott, MD, the recent history of the hospital medical staff mirrors that of physicians in general.

Jacott, who is a member of the board of trustees of the American Medical Association (AMA) and assistant vice president for health sciences at the University of Minnesota, Minneapolis, said the American College of Surgeons (ACS) was founded in 1913 to promote standards in hospital facilities, especially among their medical staffs. In 1919 an ACS-sponsored "Minimum Standards for Hospitals" described the essential features of the modern medical staff organization. In 1952 the newly formed Joint Commission on Accreditation of Hospitals required hospitals to have "an organized medical staff . . . responsible for the quality of all medical care provided patients in the hospitals and for the ethical and professional practices of its members."

But, in the 1970s, the "traditionally peaceful relationship between physicians and hospitals gave way to an environment of turbulence, surprise, and high anxiety," said Jacott. The causes were:

- Case law that made hospital managers, rather than physicians, responsible for the credentialing and monitoring of medical staffs

- Growth in government regulation

- Technological innovation
- An increase in the number of physicians, especially specialists

- The emergence of new delivery systems

The long-term result has been ero-

sion of the role of the medical staff. Today, however, a number of factors—especially the realization by medical doctors and hospital managers that they need each other—auger a new era of physician-hospital integration, Jacott said. This integration may take the form of a physician-hospital organization (PHO), a management service organization, or the "foundation model," in which a not-for-profit corporation hires physicians. Whichever model is chosen, it will have to be one that enables physicians and hospital managers to trust and respect each other, Jacott said.

For such integration truly to work, he said, physicians must have at least equal representation with nonphysicians on the new entity's board of directors. Equal board representation will have two beneficial results, according to Jacott:

- Physicians, previously less concerned than managers about controlling hospital costs, will have a strong incentive to protect the entity's financial stability. "There will be a new tradeoff between autonomy and costs," Jacott said.

- Physicians will resume their leadership role in governance, to maintain a framework of professionalism and act as advocates for patients.

Advocacy, the traditional role of the medical staff, will therefore be strengthened by the trend toward physician-hospital integration. "The medical staff of the future will be leaner," predicted Jacott, "but it will survive."

PHYSICIAN PARTNERSHIPS

The percentage of physicians who were self-employed and in solo practice fell from 37 in 1991 to 29 in 1994, said Jacott, citing a 1994 survey by the AMA. At the same time, group practices have been growing larger. The average group had 6.3 members in 1969 and 11.5 members in 1991.

The formation of physician groups is "a lawyer's and consultant's dream," said Noah D. Rosenberg, a lawyer and consultant who specializes in healthcare partnerships. "Three to five billion dollars in contracts go through our office a year," he said.

Rosenberg, a principal in Rosenberg and Kaplan, Beverly Hills, CA, has represented both physicians and hospitals in negotiations. He said he increasingly spends his time helping physicians form independent practice associations (IPAs). These are contracting groups that, although they include some spe-



In the 1970s, the "traditionally peaceful relationship between physicians and hospitals gave way to an environment of turbulence, surprise, and high anxiety."

WILLIAM E. JACOTT

cialists, have a strong primary care focus.

But physician groups are developing cash-flow problems because insurance companies and government agencies are slow in reimbursing them for their services, said Rosenberg. To solve their cash-flow problems, physicians are now looking to obtain access to revenue by forming partnerships, most often with hospitals. Hospitals need to understand that the integration physicians seek is primarily economic, Rosenberg said.

He listed five elements that are important to physicians entering relationships:

■ **Equity:** "All the tax-exempt vehicles are taking away something doctors are used to. It's not easy for someone who's been in private practice to give up the furniture, the contracts, and suddenly be an employee."

■ **Governance:** "It's more important to doctors than equity."

■ **Income stability:** "I don't mean income guarantees. Income guarantees are going to be [proscribed] by tax-exempt status."

■ **Medical care:** "Doctors are realizing that through the auspices of a group and relationships with each other, they have a shot at actually controlling healthcare."

■ **Business:** "Doctors no longer want to walk away from the business practice. They want involvement."

Rev. Dennis Brodeur, PhD, senior

vice president of stewardship, SSM Health Care System, St. Louis, said, "The profession of medicine by its nature has a certain set of moral commitments to which we hold these professionals accountable. My question is: To what extent are those professional commitments measured in the kinds of partnerships created?"

SEARCHING FOR MODELS

Healthcare systems are increasingly involved in helping physicians set up their own organizations. Kurt P. Sligar, MD, described the role of Catholic Healthcare West (CHW), San Francisco, in forming such organizations. Sligar is executive vice president of CHW.

Founded in 1988 as a network of hospitals, CHW's goal was to become a regionally integrated healthcare system, Sligar said. In 1992 a group of northern California physicians asked CHW's aid in creating structures through which they could do multiregional contracting. CHW offered them three models: the foundation model, the IPA, and what Sligar called the "super IPA." The physicians having chosen the third model, CHW invested in Primed/Hill Physicians, a California super IPA that covers 230,000 lives. Sligar said the system has also created foundations for physicians.

—Gordon Burnside, with Ed Giganti



"All the tax-exempt vehicles are taking away something doctors are used to. It's not easy for someone who's been in private practice to give up the furniture, the contracts, and suddenly be an employee."

NOAH D. ROSENBERG

QUESTIONS FOR PARTNERS

When Catholic providers partner with physicians, Rev. Dennis Brodeur said that the social justice paradigm requires them to address:

■ Activities that take human life—not just abortion and euthanasia, but also activities that deny access to services

■ The nature of physician-patient relationships, especially around reproductive choices, in order to distinguish the dimensions of moral theological thinking

■ Employment practices, such as wages and provision of health insurance

■ Acceptance of Medicaid patients

■ Acceptance of capitated lives, including some persons needing free services

■ Spiritual care—how to define it, incorporate it into practice guidelines, and ensure it is provided by multidisciplinary providers

■ The physician-patient relationship in regard to continuity, cost-related choice, and advocacy and stewardship (i.e., rationing)

With managed care partners, Fr. Brodeur said, ethical integrity issues include:

■ Ways to control costs, including medical loss ratio

■ Ensurance of quality and continuity across time

■ Protection of professional relationships (e.g., information management)

■ Advocacy within the payer community

HOSPITALS, PHYSICIANS, AND HEALTH PLANS MERGE

HOSPITALS MUST REDEFINE THEM-selves as part of a health plan competing for covered lives, not just market share, said Jacque Sokolov, MD. And physicians must do the same, he added.

THE MEDICAL LOSS RATIO

Sokolov, who is CEO of Advanced Health Plans and AHP Development Corporation, Los Angeles, pounded home the point that the "medical loss ratio"—defined as that portion (typically about 80 cents) of the premium dollar that does not go for administration—is the key concern in cost management for healthcare organizations. "It's the medical loss ratio, stupid," he said. "If our integrated delivery network or management service organization or whatever isn't affecting this number, we're wasting our time."

The explosion of healthcare spending by businesses led to managed care plans, which in turn will lead to fully accountable health plans in the next few years, Sokolov explained. Thus hospital organizations will have to assume risk and understand the difference between business risk and insurance risk, he said.



The assembly discussion format prompted lively exchanges among the more than 1,100 attendees.

"Purchasers are getting more sophisticated, and they will be assessing plans based on health status report cards," Sokolov predicted. "You are going to have to be very good at providing quality and managing your risk if you are to succeed in these new markets."

GOOD NEWS AND BAD NEWS

"The biggest challenge for a hospital will be getting over being a hospital," added Walter McNeerney, professor of health policy, Northwestern University, Evanston, IL. Sokolov agreed, saying that hospitals and physicians will have to figure out what business they are really in and align their incentives with one another so that each can survive. As fee-for-service disappears, providers' financial success will be based on an IDN's efficiency in dealing with the 80-cent medical loss ratio, Sokolov said.

"There's good news and bad news there," he said. "The good news is that hospitals will get to manage that 80 cents. And the bad news is that hospitals will get to manage that 80 cents." Sokolov explained that most hospitals are ill equipped to do such managing, but they will have to gear themselves up for it quickly as managed care sweeps the country.

TWO MINNESOTA NETWORKS

Executives of two large Minneapolis-area health systems described the very different ways their networks were created. Managed care has been a presence in the area for some 40 years, said Stephen G. Hillestad, system vice president, planning and marketing, Allina Health System. The 11 counties surrounding Minneapolis are characterized by large health plans, large hospital systems, and large physician clinics. Health maintenance organizations and preferred provider organizations make up 62 percent of the market. "Lone Ranger" hospitals and physicians are few, he said.

Allina, which was formerly six different organizations, is the result of a long merger process, said Hillestad. Until 1993 it was purely a healthcare provider. In that year Allina's leaders decided the system needed some sort of relationship with a health plan. They saw three possible options:

- To "rent" the system to an existing plan
- To create a plan that would be the system's own
- To partner with an existing plan

Allina's leaders rejected the first choice because they thought "renting" the organization would limit its growth. They rejected the second because they lacked the expertise to create a new plan. That left the third choice, and Allina eventually merged with a plan called Medica. By 1998 Allina is

expected to have a million members, 8,000 affiliated physicians, and 17,000 employees, Hillestad said.

NO LONGER 'HEADS AND BEDS'

Theodore E. Wise described a network whose development has been almost the obverse of Allina's. Wise is senior vice president of HealthPartners, a health plan that recently merged with a local hospital and a number of clinics. The system now serves 650,000 people, one of every four in the Twin Cities, Wise said. He noted that relationships between big systems are perhaps more complex in Minnesota than in other parts of the country. In fact, Wise said, 40,000 of HealthPartners' customers receive their healthcare at Allina clinics. "Our companies both compete with each other and are customers of each other," he said. Hillestad agreed: "The bottom line here is no longer 'heads and beds' but rather how we manage heads and beds—the margin."

Twin Cities buyers are sophisticated and demanding, Wise said. As a result of that sophistication and the competition between health plans, healthcare costs have dropped "far below national averages." Traditional indemnity insurers have found they cannot compete with integrated systems and are leaving the state, Wise claimed.

He predicted that the "next wave" in the evolution of Minneapolis-area care will be competition between care systems within the same plan. Wise sees employers offering

more choices to their workers. These workers will be making their choices with the aid of health status "report cards" on the system. The report cards will be widely available (on CD-ROM, for example), making consumers even more sophisticated than they are now, and this new sophistication can only make competition fiercer, Wise said.

"Consumers will, through their choices, define the system," he said. "The highest value a plan can offer to buyers and consumers is health. We are on the verge of reinventing healthcare with a member/consumer focus featuring better care, lower costs, and a consumer orientation."

—J. Stuart Showalter, Gordon Burnside, and Jude Langhurst



The Create a Healthy World Oasis offered health and well-being activities, resources, and assessments.



"You are going to have to be very good at providing quality and managing your risk if you are to succeed in these new markets."

JACQUE SOKOLOV

IDN LESSONS LEARNED

A trio of healthcare executives shared their experiences in forming integrated networks. Bruce Jensen, CEO, Holy Rosary Medical Center, Ontario, OR; John Matuska, president/CEO, St. Peter's Medical Center, New Brunswick, NJ; and Stephanie McCutcheon, regional president, SSM Health Care System, St. Louis, had this advice for other executives:

- Gain physicians' trust. "If they don't trust you, you can forget it," Jensen said.
- Pay for good consultants and legal counsel.
- Develop and communicate a clear vision.

- Plan to spend \$35 million to \$50 million over five years. (Information systems alone will cost \$10 million to \$12 million.)

- Plan small accomplishments and celebrate each as it occurs.

- Involve an ethicist and the bishop in the project early.

- Conduct detailed market analysis.

- Consult with area employers and physicians' office staff.

- Educate, educate, educate.

—J. Stuart Showalter

CHA BOARD OF TRUSTEES

Pictured here are the members of the CHA Board of Trustees for 1995-96.

New members, who were installed at the June 4 business meeting,
are marked with an asterisk.



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Sr. Ruth Marie Nickerson, CSC
President/Chief Executive Officer,
Saint Agnes Medical Center, Fresno, CA



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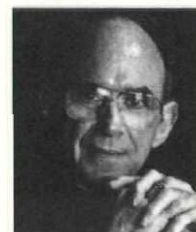
SECRETARY-TREASURER
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*Else Marie Kiefer
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Sr. Jane Marie Klein, OSF
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St. Francis Health Services, Inc., Mishawaka, IN



*David R. Lincoln
President/Chief Executive Officer,
Covenant Health System, Lexington, MA



*Richard Mark
President/Chief Executive Officer,
St. Mary's Hospital, East St. Louis, IL



Sr. Kathleen Mulchay, SSCM
Provincial Superior, Servants of the
Holy Heart of Mary, Kankakee, IL



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Presentation Health System, Yankton, SD



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Provenant Health Partners, Denver



Johnson L. Smith
Administrator, Conway County Hospital,
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Daniel J. Wolterman
Senior Vice President, Operations, Sisters of Charity of
the Incarnate Word Health Care System, Houston