

SPEAKING IN A UNIFIED VOICE

The Power of ‘We’

By PATRICK J. CACCHIONE, MPA

Illinois has more Catholic-sponsored, health-related organizations than any other state. In Illinois, the Catholic Church and its health care and social ministries have embraced what I call the power of “we.” It is a principle that has served us well in the past, and as we enter an uncertain — if not turbulent — future, we think it will help us remain relevant, true to our ethical directives and effective in serving the poor and disadvantaged.

The power of “we” is as simple as the words we choose and as complicated as developing structures that allow us to listen to each other, educate each other and discern with each other. In short, it is partnership. It is collaboration. It is acting on the knowledge that we are in this together.

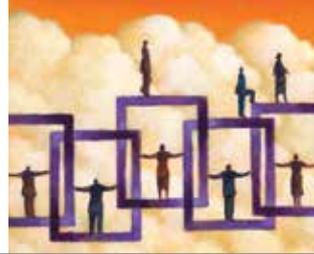
During my tenure in Catholic health care, I have participated in too many meetings where we unthinkingly refer to bishops, priests, women religious, left-of-center Catholics, right-of-center Catholics as “they” and “them” because they don’t happen to be in the meeting with us. What we mean — and should be saying — is “our brothers and sisters in ministry.” We all do it, and I count myself among the guilty.

When referring to our ministerial partners in the third person, absent any dialogue or conversation, our assumptions often implicitly question their motives, values and ethics. Working in our unilateral silos, we fail to understand and educate each other, and this only serves to divide us and weaken our collective voice. It was not until 2007, when I became the executive director of the Illinois Catholic Health Association (ICHA) that I realized the organization provided a structure to help us overcome such shortcomings in our human behavior — the firm belief that if I am right then you must be wrong. By its very structure, ICHA brings all the ministries involved in Catholic health care, the bishops, sponsors, Cath-

olic Charities’ executive directors and long-term care and hospital chief executive officers, around the same table. Open and respectful dialogue breaks down barriers, allows for cross-education and leads to sound decisions and a strong, unified voice.

ICHA is a unique membership association open to all Catholic health and social service organizations providing services in the state of Illinois and to those dioceses, systems and religious congregations that sponsor such organizations. Members include 31 religious congregations, six dioceses including the Archdiocese of Chicago, six Catholic Charities organizations sponsored by the dioceses, 42 hospitals and 41 licensed nursing homes, along with the health systems and religious congregations that oversee the hospitals and nursing homes in the state.

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Although ICHA has existed as a loose association between hospitals and church leaders since 1951, it was not until the autumn of 1995, when the Catholic Health Association began its national New Covenant meetings promoting collaboration as a way to strengthen the ministry, that the modern ICHA came into existence.

CHA co-sponsored the New Covenant process with two *ad hoc* groups, the National Coalition on Catholic Health Care Ministry and Consolidated Catholic Health Care. (See story on page 7.) The process was to discern

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the meaning of change for the Catholic health care ministry and to explore what the groups might do together on a regional and national basis that would enrich what they did locally. Following CHA's lead, Illinois conducted its own statewide New Covenant meetings at the direction of Cardinal Joseph Bernardin, and in late 1997, the modern ICHA was born.

The New Covenant model provided a guide to strengthen and promote the organized expression of Catholic caring and healing ministries by working together rather than separately. It emphasized ministry-to-ministry collaboration, because too often we were working in isolation from one another,

often dealing with similar problems but without the help and benefit of natural partners. With this as their foundation, the new ICHA's seven stated goals were:

1 Promote and realize progressively improved performances in the religious, moral and professional aspects of patient care, education, research and other programs in Illinois Catholic health facilities, and all other activities and purposes not inconsistent with the laws of Illinois.

2 Provide the means of communication and cooperation in all matters, especially sharing facilities, programs and statistics among the licensed Catholic hospitals, extended care facilities, nursing homes, homes for the aged and sheltered care homes.

3 Establish and maintain orderly channels of communication and mechanisms for cooperation and coordination among the ICHA members, thus encouraging awareness of and balanced attention to Catholic action and public witness of the church's real and active concern for human welfare, as well as the spiritual health of all.

4 Provide the means of communication and cooperation in matters of common concern with the Illinois diocesan bishops, their representatives, church support agencies and groups such as educational institutions and Catholic Charities agencies, including development of mutual support and discussion in areas of practical statewide and community cooperation.

5 Provide a forum for discussion, understanding and development of Catholic apostolic opportunities in the health field.

6 Maintain and develop liaison with the Catholic Health Association, the American Hospital Association, the

Illinois Hospital Association and other duly recognized allied associations and provide orderly and effective channels of communication with these associations and their programs.

7 Provide a forum for discussion of the responsibilities implied and involved in the assumption of stewardship for the hospitals and related health care facilities represented in the membership and their growing characterization as a public and community trust.

With these goals in mind, its board of directors charged ICHA with three activities: advocacy, education and community building, both internally and externally to the organization. Because of Catholic health care's large presence in Illinois, it was imperative for ICHA's voice to be heard as the state addressed a growing number of social and moral issues.

At this point you may be thinking that defined goals and activities make very nice documents, but how do they work in the real world?

Like this: When you gather people of good will and educate each other on the difficult issues of ethics, theology and the American health care system, a consensus usually emerges. From that consensus comes a strong, unified voice that is clear and, hopefully, convincing. Furthermore, it precludes politicians and opposing groups from weakening your position by playing one Catholic ministry against another.

ICHA is governed by its board of directors, and according to the bylaws, all membership groups (bishops, sponsors, acute and long-term health care CEOs and Catholic Charities CEOs) are represented. Each has an equal voice, and each plays a uniquely critical role.

Additionally, ICHA also has an affiliated relationship with Loyola University Chicago. ICHA, along with

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CHA, co-sponsor ethics conferences with Loyola University's Neiswanger Institute for Bioethics. ICHA also co-sponsors webinars on legal and ethical issues with Loyola's School of Law and is currently exploring opportunities to work with Loyola's Institute of Pastoral Studies.

As far as I know, ICHA is the only organization on the state or national level that operates using this inclusive model, one that establishes and uses the power of "we" to strengthen its advocacy voice. Many state Catholic conferences around the country have an embedded health care office, but they are not independent of the bishops. The Alliance of Catholic Health Care in California provides an independent statewide forum, but it represents only hospitals in its membership. I certainly do not discount the accomplishments and effectiveness of other models, but I can attest to the success of ICHA.

It is important to note that success does not always mean we prevail in the state legislature. Instead, it means that when we win or when we lose, we do it together, with a unified voice. A significant loss in Illinois came in 2011 when the state didn't renew Catholic Charities' state contracts to operate foster care programs because of our adoption placement guidelines. Up until then, five of the six dioceses in Illinois provided care, placement and oversight for foster children, and Catholic Charities cared for 1 in 5 of the state's foster children.

On the other hand, we have been very successful in protecting our reli-

gious right of conscience, developing an online education program for chaplains, outlining guidelines for ministerial positions, coordinating efforts between our Catholic Charities' home care and community services with Catholic hospital's discharge plans to reduce the number of hospital readmissions and opposing the governor's budget proposal calling for cuts that would radically and disproportionately affect the poor and underserved.

Let me express my belief that it is imperative that we embrace the power of "we" if we want to continue to be relevant, stay true to our ethical directives and serve the poor and disadvantaged in the most effective way. The U.S. is becoming a much more secular society, as indicated by the Pew Research Center's May 2015 demographic study, *America's Changing Religious Landscape*.¹ More importantly, not only is society becoming more secular, it also is struggling with definitions of religious liberty and changing social mores, as evidenced by the federal Department of Health and Human Services' contraception mandate.

In Illinois, the Health Care Right of Conscience Act was passed in 1998 and has been regularly challenged by Planned Parenthood and the American Civil Liberties Union. The initial effort was directed at pharmacists who objected to providing the "morning-after pill" emergency contraception. The Illinois Supreme Court ultimately overturned a lower court ruling and upheld the pharmacists' right not to fill the prescription on religious grounds.

In the spring 2015 session of the Illinois Legislature, the ACLU tried to pass legislation that would require religious health care facilities and personnel to provide direct referrals for patients requesting procedures that the church deems morally objectionable. The U.S. Supreme Court's recent *Obergefell v. Hodges* decision regarding same-sex marriage also is leading to discussions concerning tax-exempt status and government contracting. As social mores continue to change, there will be more challenges to the *Ethical and Religious Directives for Catholic Health Care Services*, most likely in the area of physician-assisted suicide.

Another important reason to stay united and embrace the power of "we" is the changing nature of health care delivery in the United States. Accountable care organizations, capitation and continued cost containment such as the 30-day readmission penalty are here to stay. This reality is only going to accelerate the move to joint ventures, mergers, acquisitions and other partnerships. Inevitably, these arrangements are going to find Catholic health facilities needing to coordinate and collaborate with secular, other religious or for-profit partners.

As we negotiate and implement these arrangements, it will be vital to apply the power of "we" in order to protect our mission, values and ethics. The pronoun "we" flows much more easily in a group.

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Note

1. Pew Research Center, *America's Changing Religious Landscape*, May 12, 2015, www.pewforum.org/2015/05/12/americas-changing-religious-landscape/.

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