SPECIAL SECTION

SPONSORSHIP NETWORKS

A New Model for Preserving Congregations' Presence in The Catholic Healthcare Ministry

BY SR. VIRGINIA GILLIS, RSM, EdD

Two blades of grass were talking one day. The first spoke of its strength. The second said, "Yes, but I am greener." The first blade insisted it was more flexible, but the second bragged of its height.

And, as this argument continued, a lawn mower came along and cut both blades down.

In the world of healthcare, while religious institutes struggle to maintain their individual ministries, the lawn mower of integrated health systems looms on the horizon. With radical shifts toward a focus on wellness, managed care, and a coordinated continuum of services, these community care networks promise great benefits for community health but threaten traditional concepts of sponsorship.

Collaboration is no longer an option; it is a necessity. This is probably the last decade in which women religious will have much power and influence over the direction of Catholic healthcare. Their current challenge is to respond to this situation by developing new models, new visions, of how they can work together to influence healthcare reform and retain the ministry's focus. One such vision is the sponsorship network.

Catholic healthcare institutions were founded in response to urgent healthcare needs. A renewal of vision is necessary today as healthcare shifts from an acute care to a community health focus. The sponsor can be a catalyst for this renewal. In regions where there are multiple sponsors, they can foster this renewed vision that will enable them to continue their ministry by forming sponsorship networks.

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A Network of Lay and Religious

A sponsorship network begins when sponsors in a region come together to discuss collaboration and explore ways to motivate the leaders of their institutions to better meet their community's healthcare needs. Such a network could:

- Encourage providers to assess community needs and set priorities
- Encourage collaboration among providers

Summary A renewal of vision is necessary today as healthcare shifts from an acute care to a community health focus. In regions where there are multiple sponsors, they can foster this renewed vision by forming sponsorship networks.

A sponsorship network begins when sponsors in a region come together to discuss collaboration and explore ways to motivate the leaders of their institutions to better meet their community's healthcare needs. A sponsorship network would focus on community health through more effective resource use and integration of resources among providers. Such a network encourages providers to assess community needs and collaborate to meet them, provides criteria for maintaining quality and mission, and explores sponsorship responsibilities within institutions and beyond.

The collaborative process involves five stages: preplanning, foundation building, problem setting, implementing, and assessing. A group of sponsors in St. Louis provides an example of how sponsors can initiate such a process.

- Provide sponsorship continuity
- Provide criteria for maintaining quality and mission
- Explore sponsorship responsibilities within institutions and beyond
- Coordinate other programs as needed, such as leadership formation, mission effectiveness, pastoral care, ethics, and social justice

Sponsorship networks are already springing up around the country, with sponsors collaborating and developing integrated delivery networks (IDNs). IDNs—a fundamental aspect of CHA's working proposal for healthcare reform—are networks of providers that offer comprehensive benefits and coordinate the delivery of healthcare services in specific geographic markets. (For more information, see Philip J. Karst, "IDN Development: Issues to Resolve," *Health Progress*, March 1993, pp. 24-25, 31.)

Since the primary focus of IDNs is to meet the community's healthcare needs, they run counter to the tradition of a strong revenue-producing hospital. With successful care management and wellness programs, hospitals have shorter lengths of stay and fewer admissions. The community becomes healthier, but the impact on Catholic healthcare facilities may be negative. And sponsors must be aware of these ramifications and trade-offs as they plan for the future.

Benefits of Sponsorship Networks

The impetus behind sponsorship networks is the desire to respond to community needs. And a prerequisite for achieving this goal is to focus on improving the health of the community by using resources more effectively.

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In the past, the need to survive has pushed us into a competitive modality that at times has made the community's healthcare needs and patient care secondary to the bottom line. In a small town with two competing hospitals, healthcare costs can be as much as 30 percent more than if the two facilities combined their efforts. And in larger cities the push to acquire high-technology equipment is driving the costs of healthcare sky high.

Collaboration and networking of healthcare sponsors in a region can be a stimulus for the facilities to integrate and allocate resources to improve the health of the community. Integration could be achieved in transportation, computerized information systems, and processes for guiding patients through the network of services.

With a redistribution of resources, healthcare providers could focus not on illness, but on health. They could emphasize community health, the spirituality of healing, alternative forms of healing, and holistic healthcare. This could mean providing education on healthcare beginning at a very early age.

Integral to this renewed focus on community health would be universal access to healthcare, built on existing relationships and ecumenical partnerships with other providers, such as public health facilities and community agencies.

The Collaborative Process

Since 1990, I have been involved in the formation of a sponsorship network among healthcare sponsors and multi-institutional systems in the St. Louis area (see **Box** on p. 36). In working as a facilitator for this group, I have learned a lot about the process of collaboration. It involves five stages.

Preplanning Stage The preliminary planning stage—determining the purpose, scope, and participants—involves careful planning, dialogue, and ongoing clarification. This stage is critical to the project's success.

The first step is to identify who should participate. Who are the sponsors? Should system leaders be included, or does the system's regional vice president know more about the needs and dynamics of the local scene?

It is better to begin with a core group of people who are committed to the collaborative outcome, rather than including too many persons with diverse interests, which can impede the process. Additional persons can be invited as it becomes clear who the stakeholders are.

The participants in a collaborative process have many demands on their time. The preliminary planning stage involves careful communication with the leaders so they understand the purpose and the importance of the goal and are willing to commit to the process. It is essential to outline the purpose, the steps involved, and the scheduling so participants can plan well in advance. Having a consistent group at the table is critical, since getting acquainted and building trust are essential to collaboration.

The selection of an outside facilitator not associated with any of the participants is also important. The facilitator promotes conversation among the participants and at times acts as a mediator to clarify misperceptions. In most attempts at collaboration, the participants have a history of competition and even perceptions of unfair practices. If misperceptions are not dealt with objectively, they can become insurmountable barriers. The facilitator attempts to bridge the gap between participants by helping them analyze their preconceptions.

For the St. Louis advisory board, I interviewed participants separately to determine their expectations and commitment and identify barriers to collaboration. I presented a report to the group, which allowed them to address some of the perceived barriers more effectively.

Getting acquainted and building trust are essential to collaboration.

Foundation Building The participants in a collaborative effort create the underpinnings for the process by getting to know one another and moving beyond their history and role perceptions. The group needs to build relationships and trust so they become committed to staying involved in the process.

Building such a foundation involves sorting out the group's purposes and goals, clarifying the driving force for the effort, identifying barriers, and establishing ground rules. Some ground rules might include:

- Agreeing to meet in good faith
- Acknowledging that competition exists and will continue
- Establishing acceptable and unacceptable behaviors, such as delaying progress by tabling items, criticizing without offering constructive

A CASE STUDY IN INTEGRATION

Commission on Community Health

In 1990 the 12 Catholic hospitals in St. Louis, under the auspices of the archbishop, conducted a joint assessment of the community's healthcare needs. After the report was completed, Abp. John May challenged the group to continue its collaboration to address the needs of community members who are sick and at risk. This group of hospitals, known as the Archbishop's Commission on Community Health, funded three programs:

- A nurse outreach program to respond to healthcare needs of the poor at centers where they also receive support services
- A physician referral service designed to involve physicians and hospitals in a collaborative effort to provide primary healthcare for Medicaid recipients in St. Louis County
- Joint projects with Catholic parishes to assess the specific healthcare needs of parishioners and provide new resources

The Archbishop's Commission invited sponsors to their meetings and kept them updated on their work. To get the sponsoring organizations more directly involved, the archbishop invited the sponsors and system chief executive officers to form an advisory board. This group is composed of five women religious sponsors, two men religious sponsors, one diocesan priest representing the diocesan-sponsored hospital, and the leaders from six multi-institutional systems—three women religious and three laymen.

The purpose of the board—which is modeled after CHA's description of a sponsorship network—is to provide vision and direction to the Archbishop's Commission on Community Health. This working group assesses the community's healthcare needs and recommends appropriate programs to meet them. The board also has agreed to continue exploring how collaboration can continue and has defined two purposes:

- The short-term goal is to encourage facilities to support the commission's outreach programs for the poor.
- The long-term goal is to explore ways for facilities to work together and perhaps develop integrated delivery networks to better meet community healthcare needs.

At present, the advisory board is in the third stage of the collaborative process, problem setting.

Stages in the Collaborative Process

1. Preplanning
   a. Identify participants
   b. Clarify the purpose
   c. Select a facilitator/mediator
   d. Develop a communication plan
2. Foundation building
   a. Build relationships and trust
   b. Establish a reason for being
   c. Clarify the purpose and direction (reasons for and barriers to collaboration)
   d. Establish ground rules
   e. Determine commitment
3. Problem setting
   a. Define the problem
   b. Gather information
   c. Determine the stakeholders
   d. Identify the resources
   e. Reach agreement and decision
4. Implementing
   a. Communicate and educate
   b. Build external support
   c. Structure an agreement
5. Assessing
   a. Monitor programs
   b. Continue the assessment process

suggestions, and making personal verbal attacks

- Declaring conflicts of interest
- Forming a verbal or written agreement to continue the collaborative process
- Detailing who should attend, who takes minutes, timetables, and how consensus will be determined

A major challenge during the foundation stage is to keep busy, task-oriented people working on refining the purpose. Collaboration is built on the foundation that all are carrying out Jesus' healing ministry. Collaboration is countercultural, so the reasons for coming together have to be articulated to motivate participants to stay in the process when it is difficult or conflictual.

This process has to be seen as a ball of clay that is passed around the group, with each person contributing to the shape of the final form. At the first meeting of the St. Louis sponsorship network, the group's proposed focus was scattered, ranging from specific tasks (such as developing a managed care product together) to a broad desire "to assure improvement of the health status of the St. Louis area by bringing the combined resources to solve specific identified healthcare needs." By the third meeting, the group had sharpened its focus to concentrate on two goals—short-term efforts to support outreach programs for the poor, and long-term exploration of IDNs.

Problem Setting The problem setting stage is at the heart of the process and involves defining the major issues of concern. If a problem is defined to the satisfaction of some parties but not others, the latter will have little incentive to participate.

Barbara Gray defines five interrelated judgments that stakeholders weigh in deciding whether to collaborate (*Collaboration*, Jossey-Bass, San Francisco, 1989, p. 59):

- Does the present situation fail to serve my interests?
- Will collaboration produce positive outcomes?
- Is it possible to reach a fair agreement?
- Is there parity among the stakeholders?
- Will the other side agree to collaborate?

Mediation by a facilitator is frequently necessary to sort out obstacles to collaboration and to define the problem in a way that is sufficiently broad to incorporate the agendas of all interested parties. The stakeholders' recognition that their desired outcomes are linked to the actions of other participants is fundamental to collaboration.

Timing is also critical in joint venture collaboration. A delicate balance exists between allowing adequate time to build relationships and moving ahead in a timely fashion. The facilitator must orchestrate a realistic tension between these factors.

The St. Louis network is currently in this third stage of the collaborative process. Their next step is to have a full-day retreat to address their common Catholic mission and to analyze barriers and review basic information about IDNs.

Implementing If the implementation stage is not carefully planned, well-developed collaborative agreements can fall apart. A communication plan is needed to garner external support from those who will be responsible for implementing the agreement. Identifying who will be the implementers in the problem-setting stage allows them to be involved early and to have ownership of the project.

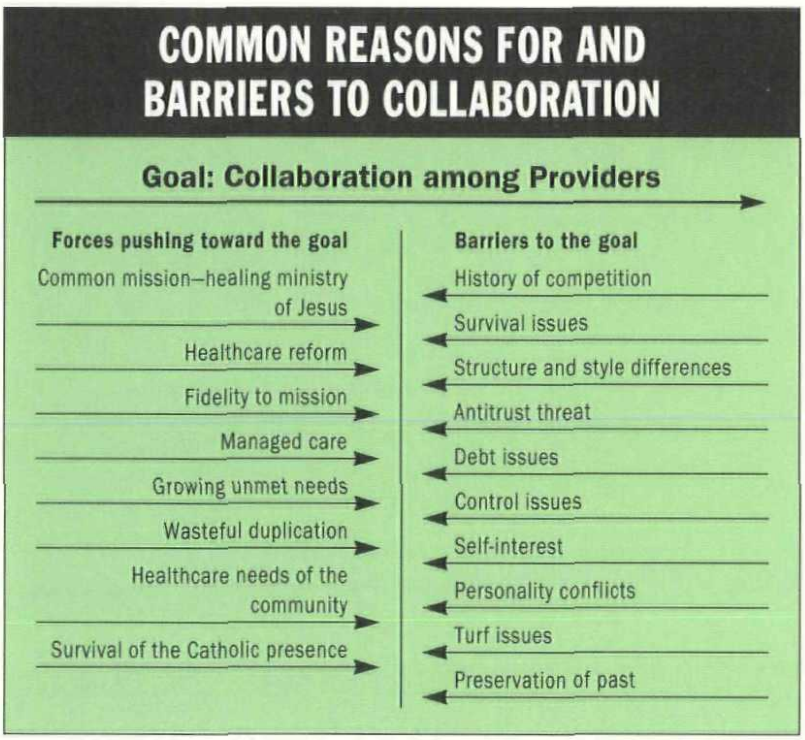
The implementation plan needs to analyze:

- How much organizational change is required
- Who has the resources to accomplish the change
- What structures are necessary to facilitate the change.

Sometimes it is necessary to create a new structure to oversee implementation, or an existing organization could be empowered to carry out the agreement with a clear delineation of roles and responsibilities.

Continued on page 41

COMMON REASONS FOR AND BARRIERS TO COLLABORATION



Collaboration is built on the foundation that all are carrying out Jesus' healing ministry.

CARE OF THE DYING

Continued from page 21

tecting a patient's right to self-determination and the state's interests to protect life. At the same time, their advocacy efforts should demand sufficient resources for holistic care for the dying.

CARING COMMUNITY

The public's demands for euthanasia and assisted suicide are in part an expression of people's fears of abandonment and isolation in an institution. Catholic healthcare providers must become ideal examples of a caring community, where patients and care givers enable each other to confront the fear of death and find support in living with human limitation. □

NOTES

1. *In re Quinlan*, 355 A.2d 647 (N.J. 1976).
2. *Cruzan v. Director, Missouri Department of Health*, 497 U.S. 261, 1990.
3. Congregation for the Doctrine of the Faith, "Declaration on Euthanasia," *Origins*, vol. 10, 1980, pp. 154-157.
4. Congregation for the Doctrine of the Faith.
5. Henry Campbell Black, *Black's Law Dictionary*, 6th ed., West Publishing, St. Paul, MN, 1990, p. 734.
6. Congregation for the Doctrine of the Faith.
7. Derek Humphry, *Final Exit: The Practicalities of Self-Deliverance and Assisted Suicide for the Dying*, Hemlock Society, Eugene, OR, 1991.
8. Committee for Pro-Life Activities, National Conference of Catholic Bishops, "Guidelines for Legislation of Life-Sustaining Treatment," *Origins*, January 24, 1985, pp. 526-528; Committee for Pro-Life Activities, National Conference of Catholic Bishops, A Commentary on the *Uniform Rights of the Terminally Ill Act*, U.S. Catholic Conference, Washington, DC, June 1986.
9. See also Committee for Pro-Life Activities, National Conference of Catholic Bishops, "Nutrition and Hydration: Moral and Pastoral Reflections," *Origins*, April 9, 1992, pp. 705-712.
10. *Cruzan: In the Matter of Westchester County Medical Center, on Behalf of Mary O'Connor*, 534 NYS 2d, 1988.

SPONSORSHIP NETWORKS

Continued from page 37

Despite good-faith efforts during consensus building, collaboration is susceptible to collapse if implementation issues are not anticipated and addressed. I cannot overemphasize the importance of process in planning and conducting successful collaborations.

Assessing The final stage consists of monitoring programs to ensure they are achieving the intended goals. This may lead to adjusting either the goals or the method of implementation. This ongoing evaluation also leads to additional problem setting, thus beginning the cycle again.

A COUNTERCULTURAL VISION

Sponsorship has two dimensions: the canonical stewardship that focuses on control of sponsored entities, and an influence on the entities' philosophy, mission, vision, and values. As radical changes occur in healthcare delivery—and the hospital ceases to be the center of healthcare delivery—the issue of control as it relates to property will become less relevant.

Thus sponsors are challenged to seek new ways to influence the philosophy, mission, visions, and values exemplified by their sponsored entities. Sponsorship networks offer a way to do that and provide a structure for the future that eventually could be the vehicle for Catholic sponsors and providers in a region to carry on the Church's healing ministry. □