



THE COSPONSORSHIP MODEL

"Sponsorship" is a relatively new term in Catholic health care, and we've been searching for its definition ever since it was coined. Rev. Michael D. Place, STD, recently defined sponsorship as "the instrument by which an institution or public ministry of the church is carried forth *in the name of and on behalf of* and in communion with the family of faith" ("Elements of the Theological Foundation of Sponsorship," *Health Progress*, November-December 2000, p. 6-10). By that definition, how do we carry on that mission within a *cospponsorship* model?

I am a member of the Sisters of Charity of the Incarnate Word, Houston, which cospponsors Catholic Healthcare West and CHRISTUS Health.* As a cosponsor, I believe that structures are only the beginning—managing relationships makes the sponsorship effort and the ministry successful.

The language used to articulate the concept of cosponsorship continues to change and is difficult to pin down, especially in complex relationships. In light of the issue of sponsorship, I would like to discuss *five communities of relationships* in the complex mix of health care communities:

- The local health care community, where care is delivered and where the healing ministry of Jesus happens
- The local civic community, which is the context in which we deliver that care



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*"Five
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ships" Are
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BY SR. OLIVE
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- The local church community
- The traditional sponsoring congregation that has had a long history in the community
- The new system

Elements holding these communities together are common traditions, spiritual experiences, goals, missions, and structures. Each of those communities is richly diverse in both concept and expression.

THE LOCAL HEALTH CARE COMMUNITY

People come together as a community to deliver health care and thus to continue the healing ministry of Jesus. Each community is unique; therefore, health care is a ministry to a particular and unique group of people. Although cospponsorship has many positive aspects, it presents challenges to that unique local community. At the system and the congregational levels, the creation of newer and larger systems may be exciting; at the same time, keeping attuned to the local communities of each individual ministry is essential and demanding.

At the local health ministry, the cosponsor asks its associates, physicians, donors, and volunteers to join in articulating the new identity of the local facility. The cosponsor asks them to accept new leadership structures and relationships and move from an old and known way to one that is not as familiar. From the local perspective, the old way

*The other sponsors of Catholic Healthcare West are the Sisters of Mercy, Auburn and Burlingame Regional Communities, CA; the Sisters of St. Dominic of Adrian, MI; the Daughters of Charity, Province of the West; the Dominican Sisters of San Rafael, CA; the Sisters of St. Catherine of Siena of Kenosha, WI; the Franciscan Sisters of the Sacred Heart of Frankfort, IL; and the Sisters of St. Francis of Penance and Christian Charity of Redwood City, CA. Our cospponsors in CHRISTUS Health are The Sisters of Charity of the Incarnate Word, San Antonio.



of doing things may seem a haven amid the challenges of today's health care environment, to which is added a changing relationship. Cosponsors must be attentive to and accepting of the tension.

Some individuals within the local community will feel lost and betrayed by the sponsorship changes. The cosponsors, health systems, and the local community must therefore be open and honest, and listen, communicate, and educate to maintain or rebuild a relationship of trust and integrity within the community. All participants must respect the pain and together move beyond the elements of grief into the potential offered in the new opportunities.

LOCAL CIVIC COMMUNITIES

Local civic communities might be the most readily forgotten group in a sponsorship change, even though the legacy of the sponsoring congregation is often tightly woven into the history of the civic community. Local residents and their children and grandchildren were often born in the sponsor's facilities. These facilities have been sanctuaries in times of major disasters and medical emergencies. They have also been a source of economic strength and frequently a place of rekindled faith. No wonder that, when a new cosponsored ministry is formed, members of the local civic community sometimes feel a severing of historic ties with the former system and a loss of control. This feeling can be especially acute if the local governing boards are eliminated, which signals to the local civic community a distance from their involvement in what they considered to be their hospital, nursing home, or care center.

Compounding this concern are worries regarding the continued operation of their facility and the potential economic impact caused by a change of direction, downsizing, or even closure of the facility.

For the new cosponsored system, it is essential that members of the civic community continue to be involved. And, where possible, they should be involved in the discussions regarding the future of the local ministry.

LOCAL CHURCH COMMUNITY

Relationships with the local church community are made more complex by the huge diversity in ethical stance of the broader society in which we live and the church in which we minister.

Keeping this community informed and educated in a timely manner regarding changes in its system sponsorship is important to ensure positive relationships. We must be the ones to tell our

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story to this unique community, and this takes time.

LOCAL RELIGIOUS COMMUNITY

Congregations have had historic relationships and transgenerational commitments to specific ministries. Women religious have been in particular facilities for years; in the past, communities typically knew that if one group left, another one would somehow appear.

That magical appearance doesn't happen anymore. More often few if any "new" sisters appear, and yet sometimes we hold onto the expectation that we have an ability to influence the ministry. Often our women religious no longer hold leadership roles, and some of our women religious who minister may even question their ability to exert influence on quality of care, mission, and values in the local ministry within a new system.

Some changes may be difficult to accept. And, as with any change, people undergo stages of grieving and wanting to go back to the way things were.

Each religious congregation needs to do its work in incorporating its membership into the vision for a new cosponsored model. Cosponsors must continue to include the members of the religious congregation in the loop of communication; before-the-fact communication, not after-the-fact communication, is a key success factor. Why? Because our associates frequently look to the members of the religious congregation for information, advice, consolation, and support. Sometimes they look for an element of discontent, too, to possibly affirm their own discontent.

How do we engage members of the religious congregation before the news hits the street, so that they can work through their reaction? We need to help them understand the greater good. Sisters can be a powerful influence for change and can combat negativity during the creation of a new system. Congregation members are an often-overlooked asset.

As congregation leaders, our understanding, enthusiasm, and commitment to the cosponsored model will go a long way in setting that emotional stage for others. Again, this sponsorship change is not about structure—it's about dealing with emotional relationships.

To maintain our integrity, we must be willing to challenge the system. Not challenging is a disservice to the ministry. But once we agree on a vision, we must enthusiastically support it—

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Mission Statement

H *Health Progress* is a forum for the exchange of ideas and information that enable members of the Catholic Health Association to shape a new future for the Catholic health ministry and promote a just U.S. health care system. Through in-depth analysis, *Health Progress* explores the Catholic health ministry's strategic strengths, fosters healthy communities, and influences the social debate on health care issues. The journal encourages examination of health care practices in light of Catholic values, especially human dignity, the common good, care of the needy, and stewardship of resources.

Accordingly, *Health Progress* focuses on:

- Ethical issues
- Leadership development
- The relationship between Catholic church teaching and health care delivery
- Reform of the U.S. health care system and integrated delivery of care
- The continuum of care and integrated delivery
- Sponsorship options
- Health and well-being
- Operational issues
- Collaborative strategies

Information for Authors

H *Health Progress's* readers have diverse interests in many aspects of health care. The journal's audience includes chief executive and chief financial officers, administrators, trustees, department heads and personnel, religious sponsors, physicians, nurses, attorneys, and policymakers. The journal covers a variety of health care management issues. These include (but are not limited to) corporate structure, finance, ethics, information systems, mission effectiveness, law, marketing, pastoral care, sponsorship, health policy, human resources, education, and governance.

SUBMITTING THE MANUSCRIPT

Manuscripts are generally 2,000 to 3,000 words, except for columns, which are 750 to 1,000 words. Manuscripts must be typed and double spaced. On a separate title page, indicate the author's academic degree and current position.

The editor will consider only manuscripts that are submitted exclusively to *Health Progress* and that have not been previously published. Submit two copies of the manuscript to: Editor, *Health Progress*, 4455 Woodson Road, St. Louis, MO 63134-3797. Enclose a disk if possible. You may submit a manuscript by e-mail also; send to hpeditor@chausa.org. Include a cover letter and address and phone number. For more detailed information, contact the editor.

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Letters expressing readers' opinions are welcome. Letters for publication should be signed. They may be edited for clarity or to fit space. Send e-mail to hpeditor@chausa.org.

FIVE COMMUNITIES

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because we must not agree unless we truly believe the change is for the good of the ministry.

THE NEW SYSTEM

The last community is the new cosponsored health care system itself. The cosponsored health ministry must bring together diverse and complex communities that are tied to the local level and transform them into one. Within this community we re-articulate the values of the organization, its mission, and its vision. We create new norms, a new culture, symbols, and styles of communication. The new system brings objectivity, synergy, expertise, best practices, and diverse traditions. It is exciting, advantageous, and challenging—but never easy.

In the past, our local ministries and our sponsored systems have had their own logos and their own identification with a single religious congregation and organizational structure. Now all this has changed. We have members within our systems who are other-than-Catholic organizations. A new challenge lies in the question: What does this have to say about our Catholic identity?

In this larger arena, the traditional structures of the corporate member and the system board relationships are challenged regarding accountability, mission, Catholic identity, and decision-making. Facing these issues, the board at times becomes paralyzed.

Change is not easy. But imagine the multiplicity of relationships as each local ministry struggles with the same problems, fears, disappointments, and hopes—all happening within a very short time frame. When one person joins a group, the group changes. In Catholic health care, who we are continually changes.

Regardless of the changes in who we are, we must establish an open, honest dialogue with all five communities in the new system, seek mechanisms to identify the questions and concerns that each has, and develop vehicles for addressing—if not answering—these concerns. We must incorporate change in our relationships with all the communities because we are a church of community. That is a foundational point of who we are: communities of faith continuing the healing ministry of Jesus. □

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