

Translating The Language of Mission

By BRIAN YANOFCHICK, MA, MBA

The mission leader role has been present in Catholic health systems for at least 30 years, in one form or another. Surveys conducted by the Catholic Health Association trace the role's development from one held mostly by members of sponsoring congregations to one held, in many cases, by lay leaders, more and more of whom have earned post-graduate degrees.

Mission leaders serve at the facility, regional and national system levels, and competencies specific to the mission role have been developed in an effort to create standards for the function and required skills. Systems have experimented with a variety of structures that reflect their theory and practice of mission integration.

Throughout its development, mission integration has focused on creating a leaven in health care institutions using that special ingredient called Catholic identity. Countless articles, columns, talks and conferences have centered on defining Catholic identity and determining what difference it makes in our institutions.

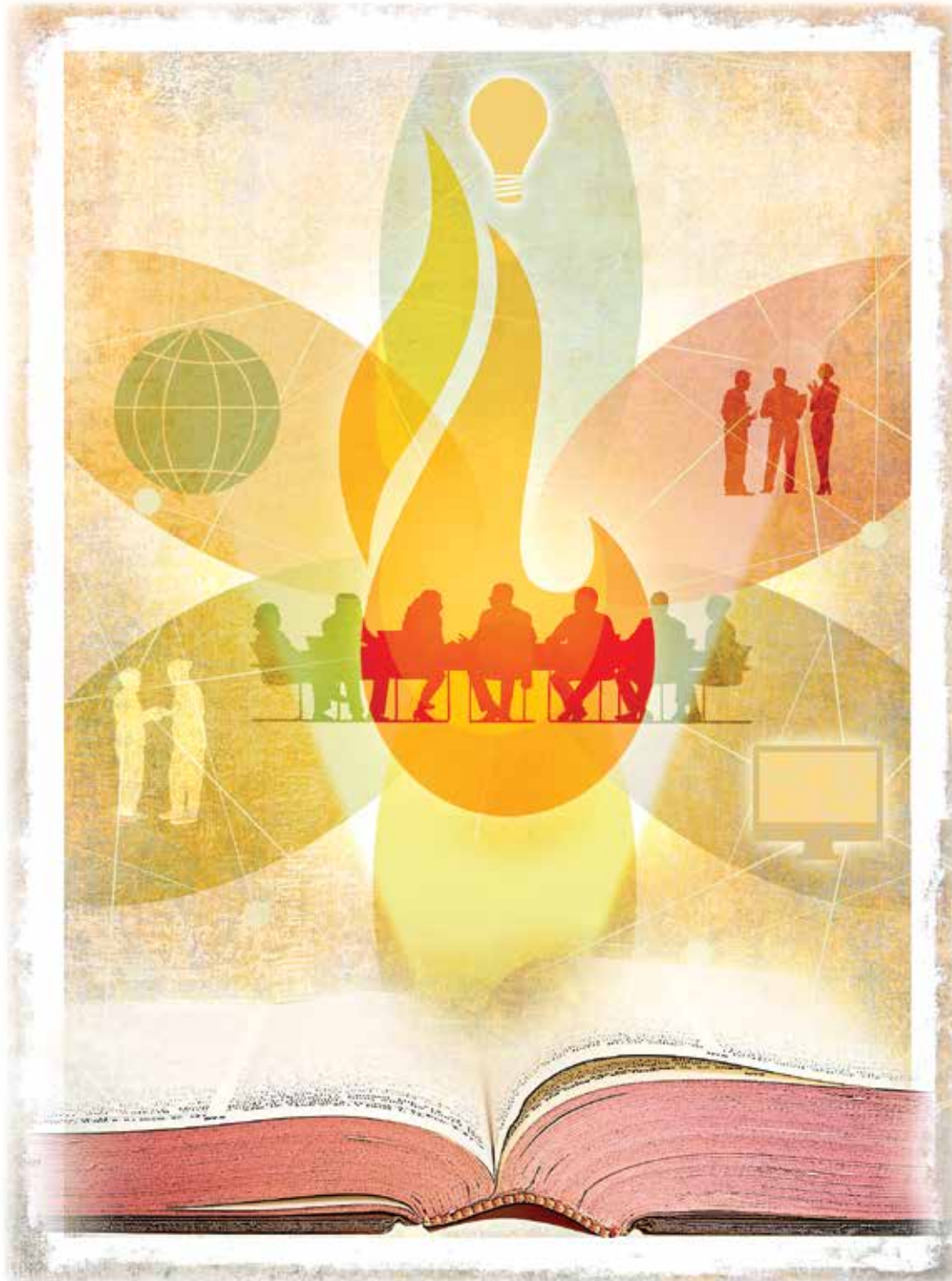
As the American health care system moves through series of significant changes, new challenges are appearing that will test our creative skills with regard to mission integration. Larger health systems have created significant physician enterprises to accommodate the growing number of employed physician groups. Accountable care organizations and clinically integrated networks are examples of new entities that employ large numbers of people, require significant resources and engage in new types of care delivery.

Many health systems outsource such significant functions as information technology and revenue cycle management. As a result, employees of different organizations work side by side

to coordinate care for patients and residents. Partnerships with other-than-Catholic organizations grow in number in an effort to give Catholic health systems the capacity to manage the care of patients well beyond the traditional episodes of care in hospital settings.

The model of mission that focused on hospitals and nursing homes and supporting staff primarily employed by the system itself no longer is adequate. The new environment includes multiple partnering organizations and staff that, in some cases, never have worked within Catholic institutions. Yet they carry our mission to our patients and residents because of the functions they perform. It is unclear to what extent our negotiations to establish these partnerships include expectations about ongoing mission integration efforts, at least of the kind traditionally expected. There often is evidence of attention to "mission fit" and compatibility in the selection of partners, but it's less likely to find provisions regarding leadership formation and other examples of mission integration work.

In the past, it often has been said that Catholic health care leaders need to be "bilingual," that is, conversant with the language of mission and the language of business and operations. The changing character of health care ministries now may require communication skills in a whole new lan-



guage that can engage both the staff of Catholic entities and of partnering organizations. Mission leaders will need to be able to translate the categories of traditional Catholic mission language into a language that engages multiple staffs from multiple organizations, all working side by side.

In some cases, readers may be surprised by the challenges this mission integration issue of *Health Progress* offers for the future direction of

mission. We hope the result will be spirited discussion and thoughtful evaluation regarding our readiness for this emerging future. That would be a welcome outcome and one that affirms the thoughtful offerings of our authors.

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