TROUBLED WATERS

Remaining a Beacon amid Change

BY DAVID J. NYGREN, M.A., M.Div., Ph.D.

The final rollout of the Affordable Care Act in 2014 will provide for insurance exchanges, Medicaid expansion, value-based purchasing and the elimination of restricted coverage based upon health status. Amid this transformation, the central challenge for Catholic health care is to maintain authenticity and relevance.

The Catholic health ministry rode the razor's edge of relevance and authenticity in the insurance debate without compromising either, but it cannot sit on the sidelines as the model of health care shifts to integrated care across the continuum, more outpatient and home care and prevention and care management.

We are at a crossroads: Will we become isolated or absorbed? Will we be at the forefront of change, or become an artifact of history? Will the church have the courage to forge new relationships without compromising its identity as servant? For guidance, we can look to *lineamenta* (guidelines) prepared for the October 2011 Synod for the New Evangelization: "The Christian must never forgo a sense of boldness in proclaiming the Gospel and seeking every positive way to provide avenues for dialogue, where people's deepest expectations and their thirst for God can be discussed." [1]

Our creative imagination needs to be mobilized once again as we enter a new era of health reform.

BACK TO THE FUTURE

While the pace and degree of change in health care may be new, these fundamental questions are not. The great social architects of 19th century Catholicism in the United States saw the need to build communities and to establish schools, churches, hospitals and a variety of social agencies within the local community as the parish. These women and men were deeply conscious of the need to build infrastructure to respond to the needs of immigrants, the poor and the ascending class of Catholics who would assimilate gradually into American life.

While relatively self-contained and serving a discreet population, the reach of these ministries was vast, particularly among those institutions beyond the parish. These included universities, hospitals, orphanages and social service outreach such as Catholic Charities. To be in service was the core value upon which all these ministries were built.

The call to serve comes most often from those who display their need for care and the trust of the women religious who can provide it to them. The call is not necessarily from the church itself, though its approbation by the church is no less important. Our Catholic tradition has been immensely strong in building social structures to support human need. Our founders never cowered in the face of obstacles and never counted the cost when doing right for others, and our creative imagination needs to be mobilized once again as we enter a new era of health reform.

RECONFIGURING AND PARTNERING

Catholic health care remains a most credible interface between church and society; some say it is the principal source of relevance for the church in the world today. Hospitals and clinics are the epicenter of human extremes — life and death, hope and despair, science and compassion. Living the condition of the extremes requires confidence in who we are, what we are trying to be and a presence that reflects authenticity to the core of our being. But what is the core? Is it moral rectitude? Is it service within the limits of our belief? Is it presence in love? Regarding the new evangelization , the *lineamenta* continues, "In a word, the situation is requiring the Church to consider, in an entirely new way, how she proclaims and transmits the faith."[2]

Catholic health care remains a most credible interface between church and society; some say it is the principal source of relevance for the church in the world today.

Our journey opens us to the creative tension between honest virtue rooted in history and heritage and stubbornness to face the future with vision when it comes to interpreting God's call. We need nuance and flexibility to discern carefully the call of our time as it relates to health care. The will is there, and the mission, but the organizational structures and delivery systems must clearly change if we are to continue to remain a major force in health care in the 21st century and beyond.

Spurred by both legislative and societal changes, we find ourselves across the health care ministry moving very rapidly into forms of relationships never before imagined. We experience the need to be market-relevant, partnering with competitors, taking on risk, growing to scale to deliver care and, most of all, being open to partner with Catholic and other traditions, confident that our roots will continue to bear fruit consistent with their planting.

The central challenge for Catholic health care is that we are, in many cases, still organized by individual charisms rather than by logical market relationships. Larger Catholic systems are addressing this with a strategic focus in markets where they will be effective within a certain geographic radius. Examples include St. Joseph Health System's affiliation with Hoag Memorial Hospital Presbyterian to create a California regional health network called Covenant Health Network; Providence Health & Services' relationship with Swedish Health Services that will boost regional presence in western Washington state; Englewood, Colo.-based Catholic Health Initiative's (CHI) recent acquisition of St. Luke's Episcopal Health System in Texas; and Cincinnati-based Catholic Health Partners' recently announced acquisition of Kaiser Permanente Ohio all reflect rapid efforts at regional consolidation and, often, strategic alignments with other-than-Catholic facilities.

What these systems demonstrate is a willingness to enter into relationships with partners in order to create sufficient density to fund capital within a market to advance integrated care delivery. Freestanding hospitals or systems that don't have a critical mass of quality services within a market or that are distributed across broad geographies will continue to be challenged. They will likely need to partner with other-than-Catholic enterprises to survive, or to quickly attach where possible to a Catholic network that can provide them scale, relevance, debt financing and the ability to attract physicians to meet the requirements of clinical integration.

Without being part of an integrated network,

hospitals run the risk of being cut out of contracts, of losing physicians who choose to enter integrated networks so that they can engage in joint contracting, risk bearing, incentive payments, evidence-based care and sharing patient data to meet emerging standards of care.

This view was expressed loud and clear during a March 2013 conversation with Anthony Tersigni, Ed.D., FACHE, president and CEO of Ascension Health Alliance, whose subsidiaries include Ascension Health, the nation's largest Catholic and nonprofit health system.

"For us, the watchword for health care today is unsustainability," Tersigni said. "With the size of the federal budget deficit, annual increases in the Medicare budget, issues with state Medicaid and the continuing transfer of cost to employers and consumers, we need to change if we are to continue to carry out our mission of health care for everyone, with an emphasis on the poor and vulnerable."

According to Rod Hochman, MD, president and CEO of Providence Health & Services, Renton, Wash., his organization went through a similar process to better connect care, and in an era of declining reimbursement, increase efficiencies. In 2012, Providence and Swedish Health Services, based in Seattle, formed an affiliation in which Swedish formally joined the Providence Health & Services five-state health care system while remaining a separate, secular brand. The affiliation expanded both organizations' ability to carry out their individual missions, and the affiliated system now includes 32 hospitals, 400 physician clinics, senior services, supportive housing and many other health and educational services employing more than 64,000 people across five states. "This is a unique, local solution to a national problem that will help Providence and Swedish better deliver high-quality, low-cost care," said Hochman.

TAKING ACTION

While papal invitations to think creatively and to be in dialogue with culture are plentiful, the U.S. church and politics seem polarized, or at least limited in the ability to compromise effectively. The basis for the new model for providing health care in the U.S. may seem to be exerting influence on the Catholic ministry to get in or out of health care. If we don't make choices today with a vision focused on the longer-term value, we risk losing the legacy of the last hundred years of the ministry. This would be reckless at best.

There are three immediate challenges for Catholic health care:

1. Address the extent and means for partnering with non-Catholic providers. Many systems have worked with bishops, canonists, ethicists and theologians to imagine the next phase of Catholic presence in our major metropolitan communities. Focusing on the common good, the healing ministry of Jesus and the spirit of the founders, Catholic health care leaders and boards understand that partnering with others who share our values without compromise to identity is indeed the greater good. This is a challenging proposition, particularly where state and federal laws come very close to material cooperation and potential for scandal. Thanks to the broad vision of women religious over the last century and the bishops who have worked courageously to support their good works, the Catholic healing ministry has the benefit of its size to be the leading force for good.

The University of California, Los Angeles (UCLA) is a large, successful public research university health system and a prime illustration of this sort of institutional transformation. David Feinberg, MD, M.B.A., president of UCLA Health and the CEO of UCLA Health System, said, "As we looked for different partners, we found that Catholic institutions, while not the only ones we would consider partnering with, are in so many ways a match for our public mission. Like a university, there is no exit strategy — they are in it for the long term — and there is a commitment to provide care for the next 100 decades. Like us, too, they provide care for all people, with an emphasis on the poor and vulnerable. Our commitment is to care for all the people of California — with or without insurance, here legally or not — and that commitment also goes to the deepest part of Catholic health care."

If we don't make choices today with a vision focused on the longer-term value, we risk losing the legacy of the last hundred years of the ministry. This would be reckless at best.

2. Consolidate Catholic ministries to provide market presence before that choice is lost. Sponsors in distributed markets who want to sustain

their hospital ministries should seek rapidly to partner with other Catholic providers to build out an integrated care delivery model. The May 2013 decision by the Sisters of Charity of Leavenworth Health System to shift sponsorship of Saint John's Health Center in Santa Monica, Calif., to the sponsors of Providence Health & Services is such an example.

Maintaining market presence is indeed a critical and common strategy driving some of the new configurations in Catholic health care. Hochman talked passionately about the importance of Catholic health care's commitment to serving communities: "With Catholic ministries, the mission is clearly delineated. Our mission to serve everyone who comes to us for care, regardless of their ability to pay, is at the heart of how we deliver care."

We must come closer to culture to transform it, rather than recede as if our identity is compromised by others who do well with us.

At Ascension Health Alliance, Tersigni agreed: "We are clearly the low-cost, high-quality provider in many of our markets," he said, but he noted that serving communities is far from the only unique contribution of Catholic health care. "We provide a distinctive approach to holistic care focusing on the mind, body and spirit," he said. "The bottom line for the Catholic health care ministry is that we have a responsibility to care even when we can't cure. We look at people differently, in totality, and address each aspect of their life, not just disease."

3. Determine how as a church we can transform society through our health care ministry. Perhaps the biggest challenge is for bishops, sponsors and leaders of Catholic health care to take the longer-term view. What impact should we, as church, have in our society, not just within our church? The great social engineers of the 19th century saw the parish and neighborhood as the dominant communal structure for shaping community. Churches, schools, hospitals and parishes defined the boundaries of our Catholic believing context. Today, the invitation to put our resources together to advance the common good takes us beyond our ethnocentric limits to be credible witnesses to the core message of Jesus' healing without regard to polity, class or preference.

A number of the leaders of health care institutions have noted that Catholic health care has not cornered the market on compassionate care for the most vulnerable. As interim president and CEO of CHE Trinity Health — a multi-institutional Catholic health system spanning 21 states — Judith Persichilli, RN, M.A., underscored: "Our distinctiveness emanates from the charisms of founding congregations, which impacted the culture of that particular ministry and how they responded to the most urgent community needs. But we have to recognize that other organizations make the same contribution in a secular way. In uniting, we can create a more powerful, unified voice to advocate for the vulnerable in our society."

The trick will be to maintain core Catholic values as organizations join forces. "It's not an issue we have yet had to confront," said Deborah Proctor, president and CEO of St. Joseph Health System, Irvine, Calif., which in February 2013 announced the formal completion of an unprecedented affiliation with Hoag Memorial Hospital Presbyterian, a regional health care delivery network in Orange County, Calif. The motivation for the partnership, known as Covenant Health Network, was to enhance institutional strength to address the tremendous gap in access to care in a country without a public health system.

"In our affiliation with Hoag," Proctor said, "they are remaining Presbyterian and we are remaining Catholic; we have a common set of values, but retain out distinct heritages. The whole idea is that Catholic health care must reinvent itself to create a transformed system of care that meets the needs of our communities — maintaining the moral imperatives we've always had."

The Catholic health ministry already possesses precisely what society is in need of today — integrated care delivery. Moving forward, we must expand our sense of the common good. During the Civil War, Catholic women religious from 28 congregations constituted the largest pool of nurses to care for the wounded and dying. Were we then focused to the same degree as today on the moral edges, or on pure services to the other? Why are moral restraints more compelling than the human impulse to goodness?

The Catholic tradition adds distinctive value when we shape palliative care; dying in the context of a community of faith; the values that support life and health through wellness and preven-

tion; health care as a right, regardless of the ability to pay; the triumph of compassion when faced with life-changing illness; and the meaning of life and death in the context of a God who loves us.

If Catholics are virtuous at all, it will be our steadfastness to goodness that must prevail through the health care ministries. We will balance the economic good and the common good; the individual conscience and science; and spiritual health and artificial preservation of life. We must come closer to culture to transform it, rather than recede as if our identity is compromised by others who do well with us.

CONTRIBUTING TO HEALTH AND PROGRESS

If we are to honor the anguish of human suffering and use our resources effectively with the advent of health reform, we will need to enter into far more complex relationships. This will require clarity of our own identity; diligence in mastering structural alternatives where partnering is the best alternative to serve; and courage to advance new leaders and boards competent to fulfill the duties that are entrusted to them. The Catholic work ahead is not unilateral control by a congregation, a bishop, or a public juridic personality alone. It is likely participation as an equal partner in a network of Catholic and non-Catholic enterprises in contiguous markets.

If we cannot do what is right by these ministries, we must do what is necessary to transition them to a place of continuing to serve the people who generously believed in us in building them, the communities that called us into being. Remaining in health care for the next 100 years will require us to think systemically, organize by market and envision a new horizon for our faith. We will be leaven, the cathedral amid the secular winds, the hub of a network that enables all people of good will to come together to promote human health and progress.

DAVID NYGREN is a social and organizational psychologist who specializes in board effectiveness, organizational strategy and executive leadership. Formerly executive vice president at DePaul University, Chicago, he spent 10 years as senior partner at Mercer Delta Consulting LLC, where he founded and led the corporate governance consulting group. In 2007, he established Nygren Consulting LLC, Santa Barbara, Calif.

NOTES

1. Synod of Bishops, "*Lineamenta*," *The New Evangelization for the Transmission of the Christian Faith*, Chapter 1, section 5. www.vatican.va/roman_curia/synod/documents/rc_synod_doc_20110202_lineamenta-xiii-assembly_en.html.
2. "*Lineamenta*," Introduction, section 3.

JOURNAL OF THE CATHOLIC HEALTH ASSOCIATION OF THE UNITED STATES www.chausa.org

HEALTH PROGRESS®

Reprinted from *Health Progress*, July-August 2013