Mission and Outreach: Whose Work Are We About?

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The 92nd Catholic Health Assembly is upon us with its focus on "Touching Lives, Healing Communities." In this context, it is important to reflect on the role of the mission leader in shaping the relationship of his or her facility or system to the communities it serves. Along with the vital role the mission leader plays in creating a vibrant workplace imbued with a commitment to serve as Jesus did, he or she also offers vital leadership to the organization in shaping its relationship beyond the walls of a facility to people, policy makers, community organizations, and others.

Many larger systems fund staff positions whose specific responsibility may be to interact with local, state, and federal policy makers. They may also fund staff positions that develop community health programs in collaboration with other local organizations. For financial or other reasons, many facilities may not have these staff persons in place and often the mission leader is seen as the person responsible for that function. In the latter case, the mission leader's role is most likely very clear as they discern needs and focus for their community relationship efforts. In the former case, the role may not be so clear. There is even a danger in presuming that, because these functions are staffed by others, the mission leader need play only a peripheral role, or no role at all. That would be unfortunate.

We are aware of the constant tension Catholic health care faces as it struggles to integrate the best financial, clinical quality, safety, and other practices in a way that is true to our stated mission. This tension is often understood to be played out internally. However, it is also played out in the ways facilities and systems design and implement their outreach strategies. The mission leader is challenged to be engaged with management as it struggles with internal operational issues. He or she also plays a vital role in shaping the assumptions and principles used to design and implement community outreach efforts.

How is this done? To begin to answer that question, the distinctions offered by Sr. Helen J. Alford, OP, and Michael J. Naughton in their book *Managing As If Faith Mattered,* may be helpful. In the chapter titled "The Purpose of Business," they differentiate among the motivations and ends of three models of business: the stakeholder, the shareholder, and the common good models. By briefly exploring these models, I hope to offer them as a framework within which a mission leader would help his or her organization to evaluate the assumptions and outcomes for their outreach efforts. I apologize to the authors in advance for what is assuredly an oversimplification of their thinking.

Sr. Helen and Naughton distinguish two kinds of "goods," or goals, pursued by an organization. What they call "foundational" goals are illustrated by good financial performance, the generation of capital for investment, and investment in technology that improves efficiency and production. By contrast, "excellent" goods or goals are illustrated by the development of a workplace that helps its participants grow in professional competency, personal satisfaction, and commitment to a common purpose.

SHAREHOLDER MODEL

With this framework in mind, Sr. Helen and Naughton discuss the "shareholder" model of business. The goal of this model is simply the "maximization of shareholder wealth." This translates in the not-for-profit context as maximizing the financial margin to be re-invested into services as the guiding goal for all activity. It also translates to the goal of always positioning the organization in a positive light. This model recognizes the need for attention to both foundational and excellent goals, but orders the excellent goods in service of

the foundational ones. The authors offer an interesting illustration of this in the motivation a company may have for not marketing alcoholic beverages or cigarettes to a young, poor population. In this model, the company may choose to refrain not because of the good of the target population but because of the image problems it may cause the company. The shareholder model focuses on the good of the company.

Organizations operating out of the shareholder model will most likely develop their outreach efforts with two goals in mind, to drive admissions to their clinical services, and burnish their "caring" image in the community. And so in this model, a parish nurse program may be evaluated less for its preventive health potential and more for documented referrals to the sponsoring organization. Other local hospitals or community programs may be seen as competitors rather than collaborators in community health.

Stakeholder model

The "stakeholder" model identifies groups that have an interest in the organization such as employees, suppliers, lenders, and members of the community. This model's strengths include an inherent concern for the interests of each stakeholder group, such as fair wages and job development for employees and contributions to the quality of life of the community by the business. The drawback is that this model may not create a sense of shared purpose or value, and instead seeks a "balance of power" among individual interests.

Those who work from a stakeholder model may have done good homework to identify the various constituencies with whom they interact in a community. They may indeed offer effective outreach efforts that target their identified needs. However, there is a danger that programs in this context create dependency rather than empowerment.

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Common good model

Finally the "common good" model prioritizes foundational and excellent goals so that business activity creates a "community of work" within the organization and contributes to the good of the external community as well. The foundational goals are essential, but are ordered to support the "excellent" goals both within the organization and in the larger community. In this model, the good of the patient and the good of the community are central, even if it means the organization settles for less-than-optimal financial performance. In addition, the relationship with stakeholders is developed toward common goals rather than balancing individual needs.

Those using the common good model should be able to demonstrate that their community programs not only enhance the community's access to their clinical services but also serve portions of the community that offer no benefit in return. An example of this would be a hospital that has developed a consistent, aggressive program for enrolling children in its state's SCHIP program even though they do not offer any inpatient pediatric programs. They are not converting anyone from a non-paying to a paying customer, but sim-

ply removing an important barrier to access to care. In this model, a Catholic health care organization would also expect and facilitate involvement of its employees in outreach efforts.

In order to encourage a movement toward a common good approach to outreach, the mission leader might consider the following questions:

- How does a Catholic health care organization apportion resources for its community programs so that allowance is made not only for programs that may support admissions but also serve community needs that may not directly bring benefit to the facility?
- Can a Catholic health care organization demonstrate success not only in using "other people's money," that is, foundation funds, to support community programs but also a "tithe" from the revenue it generates for effective programs?
- Does the Catholic health care organization have a formal method for periodically evaluating community health risk factors and designing programs to address them?
- Does the Catholic health care organization act as a catalyst and convener of the community to address needs or simply act as a competitor with other health care organizations for community recognition?
- In our interaction with policy makers, what portion of our discussions is spent on advocacy for policies that enrich the human community versus concerns about financial reimbursement? Do we differentiate ourselves from secular not-for-profits in the emphasis of our advocacy or do we sound much like them with a similar financial focus?

These questions are important for the spirit of an organization. They begin to address not just the "ends" of its community action but also its core motivation. This is a mission issue. In the admonition of Jesus who said, "when you did it for the least of my brothers and sisters, you did it for me," the "me" is about Jesus, not about us.

Justice—A Core Competency

In 1999, mission leaders from among CHA's membership named core competencies for the mission role. The results of their work may be found on the member side of the CHA web page at www.chausa.org/Mem/MainNav/Mission/missionintegration/competencies. Among these competencies is *justice,* defined as "the knowledge of and ability to understand and apply social teachings of the Catholic Church and environmental-ecological justice to the health care organization's role as caregiver, employer, community member, and partner."

This is a competency that should be evident in the fabric of Catholic health care in all of its expressions. The mission leader is an important resource who offers guidance not only about the internal operations, but also about their relationship to the community. The April 2007 edition of *Hospitals & Health Networks* magazine carried an article by Bill Santamour entitled "A Mission to Listen." He states that, despite the many good things hospitals are doing through their community programs, hospital CEOs are not always as in touch with their communities as they think they are. Time and again, community focus groups reveal feedback that does not match the hospital's more positive self image. He quotes Rick Wade, senior vice president for strategic communications at the American Hospital Association when he says, "Hospitals need to re-establish trust in their communities. They need to forget for a minute about getting their message out and just listen." Mr. Santamour points to a resource entitled Community Connections, Strengthening Community Trust: Strategies for CEOs. It may be found at www.caringforcommunities.org. It offers a detailed method of getting an executive in touch with his or her organization and community. Using tools such as this, a mission leader can help his or her executive team to facilitate an important listening process that will bridge the gap between perceptions and realities.

Whatever the resources available to a facility or health system to staff outreach, the mission leader is a key part of the process that shapes the motivations and goals that guide the design of our outreach. It is a work of constant influence, relationship, engagement, and learning. ■

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