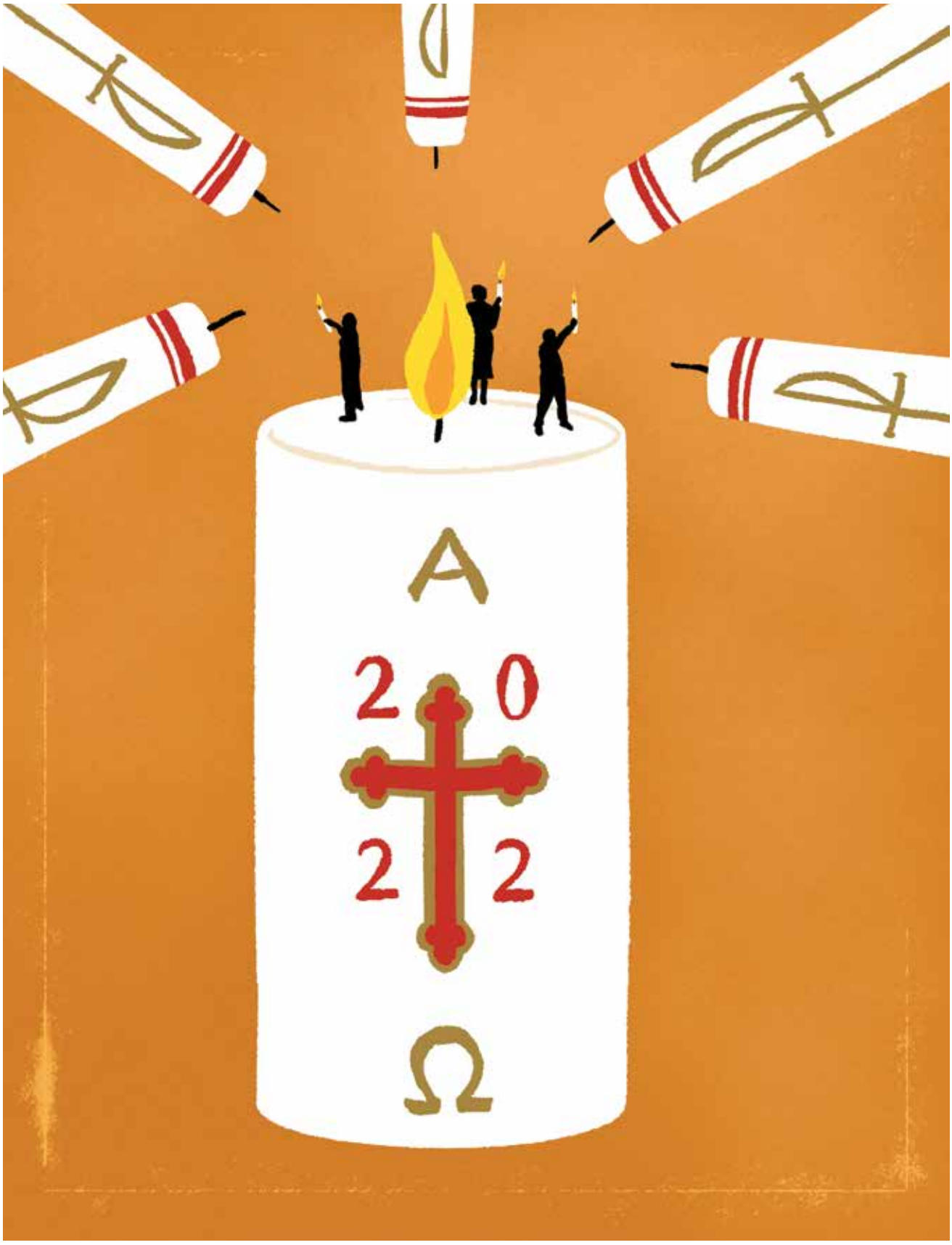
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Challenges For Sponsorship Today

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One of the achievements of the post-Vatican II health care systems was to develop the concept of "sponsorship." As long as institutions were founded and owned by dioceses, parishes or religious congregations, and led by priests or religious, their Catholic identity was secure. However, the aggregation of health care institutions into systems, at times involving more than one religious congregation and spanning multiple dioceses, called for a more creative approach. Hence, the idea of sponsorship was born.

As defined today by CHA, "sponsorship is a structured relationship through which the sponsor, in the name of the Church, directs and influences a ministry that meets an apostolic need and furthers the mission of Jesus."[1] A typical sponsor is a specific group of religious (sometimes including lay people) recognized and chartered by the Dicastery for Institutes of Consecrated Life and Societies of Apostolic Life at the Vatican. The canonical designation for such a sponsor group is "public juridic person (PJP)" or, more recently, "ministerial juridic person."

For several decades, this structured relationship has grown and matured, providing effective ecclesial accountability and mission oversight to health care in the United States.[2] But as in any living relationship, time brings new challenges. What follows are five questions identified for the future. Examining these queries provides an opportunity to address them with the creativity and purpose that has characterized Catholic health care until now.

Will sponsorship become a predominantly lay ministry?

The concept of sponsorship was originated by religious women and men, and they populated the earliest PJPs.[3] In time, though, some qualified Catholic lay people were invited to join the PJPs. However, the charters or bylaws of most PJPs still specify that a majority of the members must be religious or that they must be chaired by a religious. Today, the number of women or men religious has declined precipitously, leaving fewer qualified to serve in health care sponsorship roles. Also, the areas of ministerial interest or preparation for today's younger members may lead them in different directions. At the same time, PJPs are accountable to the Dicastery for Institutes of Consecrated Life and Societies of Apostolic Life, a situation that could become quite anomalous if the membership did not include mostly religious.

Will the specific charisms of the religious congregations have any enduring influence?

Each religious congregation is characterized by a founding grace or "charism," defined as a gift of the Holy Spirit for the sake of building up the Reign of God for the good of the Church.[4] Expressions of the sponsoring congregation's charism typically influenced the statement of the health ministry's mission. When two or more congregations joined in a co-sponsorship arrangement — for instance, in a single PJP — careful

wordsmithing expressed a mission inclusive of both charisms.

On reflection, however, we might observe that congregational charisms — such as mercy, charity, divine providence, bringing good help (Bon Secours) and imitation of the devotion of the Blessed Mother or St. Joseph — are not exclusive to any religious institute. They are gifts and ideals held in common by all those baptized. While the heritage of the founding congregations deserves to be honored, the current mission of the health ministry is what should be guarded and promoted by the current sponsors.

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Moreover, in its "Dogmatic Constitution on the Church," the Second Vatican Council affirmed the holiness of the whole people of God and the graces distributed to all. [5] It notes, "... all the faithful of Christ of whatever rank or status, are called to the fullness of the Christian life and to the perfection of charity."[6] Further, "this holiness of the Church is unceasingly manifested, as it ought to be, through those fruits of grace that the Spirit produces in the faithful. It is expressed in multiple ways in those individuals who, in their walk of life, strive for the perfection of charity ... ."[7] Thus, the laity who serve in a sponsorship role as an exercise of their own Christian vocation are guaranteed the grace (charism) to discharge it.

What relation should sponsorship have to trusteeship and mission integration?

Having worn all three hats (sponsor, trustee and chief of mission integration), I am sensitive to the distinctiveness of each. The sponsor's role, as defined earlier, is typically expressed through specific authorities reserved to them, such as appointment of board members, approval of the president and CEO, change of mission or bylaws, and oversight of stable patrimony,[8] all by accountability to the Dicastery for Institutes of Consecrated Life and Societies of Apostolic Life.[9]

The trustees, in turn, have oversight and legal responsibility for the enactment of the mission, including areas such as strategy, quality, finance, human resources, legal, marketing, etc. They receive accountability from the CEO and management leaders in the various areas.

Among the management areas is mission integration. Mission executives oversee or contribute to multiple areas. To illustrate, below are the seven areas of mission competency identified by CHA. Each of these competencies reflects the skills needed at different levels, or tiers, of the organization with appropriate actions for each.[10] (For example, strengthening Catholic relations might occur at a local [parish] level, a diocese, nationally or with the Vatican.)

Catholic Identity: Stewards Catholic identity and strengthens Church relations.
Strategy: Ensures the centrality of mission in strategy.
Operations: Incorporates the mission and values into all operations of the organization.
Formation: Champions formation at all levels of the organization.
Spirituality: Nurtures spiritual health.
Ethics: Promotes organizational and clinical ethics.
Advocacy: Represents the needs of persons who are affected by poverty and are marginalized.

As noted above, mission is an area of management, accountable to the board of trustees. The board is appointed by the sponsors, hence they are accountable to them. What looks like a clear delineation of responsibilities is, in fact, sometimes confusing or conflictual, as when the board and sponsor are the same individuals, or when sponsor representatives oversee or participate in management areas such as mission formation within the organization. While mission is charged with stewarding Catholic identity and strengthening Church relations, the sponsor exercises final accountability to Roman officials. Who should appropriately deal with local bishops, a sponsor or a mission representative?

What are the questions sponsors should be asking about services provided by businesses either owned or created by the health care system, when those working for the businesses are not system employees?

This query relative to sponsorship arises because of the growth of diversified operations

within health care systems. These diversified operations include a portfolio of businesses developed or acquired by the system. Such operations may include health care services such as urgent care; ambulatory surgery centers; outpatient imaging centers and other lower-cost sites of care; nonacute services such as home care, hospice and behavioral health; and even business services such as revenue cycle management and supply chain consulting. These services may be far outside the geographic footprint of the inpatient operations of the system, even extending internationally. They can serve to offset profitability deterioration in the traditional acute care services since they generate higher margins with less capital investment. Furthermore, they may be organized as for-profit subsidiaries in order to provide market-based benefits and compensation. Thus, their personnel are not technically employees of the system, and their services often do not carry the system's brand.

One place to begin might be to think of the portfolio company as an agent of the Catholic health care system. Hence, it would be appropriate to ask if its employees are guaranteed a work environment characterized by social principles of human dignity and respect, even if they are not considered to be working for a Catholic organization.

Some diversified services are provided entirely via phone or computer (for example, patient scheduling, nurse triage and patient transfer). Employees of these operating units never see a patient in person, nor ever visit a clinical setting. In fact, in this post-COVID-19 world, they may even work from home and rarely see other employees in person.

While there have always been back-office employees who were isolated from bedside care, their numbers were small compared to the amount of caregivers, and their offices were often in a section of or nearby the hospital itself. A big difference today is that the number of such employees has grown astronomically, and the entire health system, including the acute care ministry, depends on their efforts for efficiency and financial viability. Therefore, sponsors examining whether these employees' business environments reflect their system's model of workplace dignity is essential to sound operations. An area like patient billing and insurance may require thousands of employees given the convoluted state of health care insurance in the United States.

What is the role of sponsors in regards to digital operations?

Digital operations can include any instance when a patient or a provider is touching a screen. Examples include personalized patient tools that enable mobile health, such as smart phones, wearables and even telehealth, as well as physician-facing applications that enable more effective and efficient clinical outcomes. All of these are constantly improved and updated by machine learning and artificial intelligence. As much as a quarter of the system's income may be derived from diversified and digital operations, thus supporting the core operations, which may be underfunded by Medicaid and Medicare and include uninsured patients.

Catholic health care is a ministry of the Church, an expression of Jesus' description of the Final Judgment: When I was sick, you ministered to me. The fact that this ministry has evolved into new ways of serving the sick, while maintaining traditional patient-centered care, doesn't detract from its fundamental premise: "You ministered to me."

As sponsors view the consolidation of smaller systems and free-standing health care centers into larger growing systems with multiple diversified businesses, the question of their competency and responsibility arises. How much do they have to know about the clinical, legal, financial and technical intricacies of health care services as they are evolving? What qualifications will sponsors of the future need?

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Judgment: When I was sick, you ministered to me. The fact that this ministry has evolved into new ways of serving the sick, while maintaining traditional patient-centered care, doesn't detract from its fundamental premise: "You ministered to me." Whether lay persons or religious, sponsors carry this mandate as a sacred trust. It is their responsibility to direct and influence the ministry so that it furthers this mission. One way they do this is by appointing trustees who are not only knowledgeable of the various technical areas, but who also honor and serve this sacred trust. At the same time, sponsors need to attend to their own growth in understanding changing health care needs and resources so that they can authentically serve the sacred mission.

We can be sure, though, that the same grace that inspired the creation of "sponsorship" will also be available to guide its evolution to address new needs in health care's ever-changing environment.

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NOTES

1. *Guide for Sponsors in Catholic Health Care* (St. Louis: Catholic Health Association, 2021), 5, https://www.chausa.org/docs/default-source/sponsorship/cha-sponsorship-guide.pdf?sfvrsn=0.
2. Many of the observations and questions to follow apply as well to educational institutions at all levels and to other Church works, but the focus here is health care institutions.
3. *Guide for Sponsors*, 3.
4. U.S. Catholic Church, *Catechism of the Catholic Church: Second Edition* (Washington, DC: United States Catholic Conference, 2011), 799-800.
5. Second Vatican Council, "Lumen Gentium: Dogmatic Constitution on the Church" in *Vatican Council II: The Conciliar and Postconciliar Documents*, ed. Austin Flannery (Wilmington, Delaware: Scholarly Resources, 1975), Chap. V, "The Universal Call to Holiness."
6. Second Vatican Council, "Lumen Gentium," paragraph 40.
7. Second Vatican Council, "Lumen Gentium," paragraph 39.
8. "The patrimony or temporal goods of a public juridic person in the church, such as a religious institute or one of its parts, is usually classified either as 'free' or 'liquid' capital, or as 'stable' capital or patrimony. Stable patrimony is that which is destined for the long-term security of the members (in the case of a religious institute) and of the sponsored works. In general, it can be said that stable patrimony consists of lands and buildings, of certain other types of property (such as a specialized library, historical or cultural items), long-term investments and endowments, and restricted funds set aside for a specific purpose." From the following: Fr. Frank Morrisey, "What Is Stable Patrimony?" *Health Progress* (March/April 2008): 14-15.
9. *Guide for Sponsors*, 10.
10. "The Mission Leader Competency Model," Catholic Health Association, https://www.chausa.org/mission/mission-leader-competencies.

QUESTIONS FOR DISCUSSION

In this article, author Sr. Doris Gottemoeller, RSM, addresses the importance of charism in the sponsorship of the Catholic health care ministry.

1. Are you familiar with the charisms of your founding congregations? How do these charisms inform your work in health care?
2. How can sponsors, trustees and mission leaders work together in order to ensure that the health care ministry not only remains true to its Catholic identity, heritage and mission but also is able to adapt and thrive in the ever-changing, complex industry of health care?
3. If you are a sponsor, how have you seen your role or responsibilities change over time? What have you learned most from that?
4. When you consider the questions posed in this article, how do they prompt you to think about the future of the ministry? How is your system preparing for this future?

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