



ALWAYS WITH US

CARING FOR THOSE WHO ARE POOR

Faced with increasing difficulties in providing services to those who are poor and yet deeply committed to such care, members of Catholic Health East (CHE) recognized the need to examine how we are providing such care today and how we can do so in the future. A group of people within the system office was asked to study the situation as it is today and to provide background, information and recommendations on how we can proceed together.

It is hoped that Always With Us will be used for study and discussion throughout the System with Sponsors, Boards, physician leadership, management, and all of our colleagues; that the recommendations it contains will be implemented; and that it will serve as a basis for further growth and further learning.

I. WHY WE ARE CONCERNED

Tabitha is 19 years old and in labor. She has no insurance, no family support, and she has had no pre-natal care. Problems have arisen and her delivery looks as if it will be extremely difficult. She is frightened, poor, and alone.

Tom is 42 years old. He was part of a major lay-off at the company where he had been employed for 15 years. His benefits have run out. After enduring pain for several months, he finally saw a doctor who ordered several expensive tests. He has just been diagnosed with advanced colon cancer. He is terrified and his wife and children are too.

Mohammed is a refugee from a war-torn country. He is 35, has no documentation, and fears being discovered by the INS. His wife and three children are also refugees. His 6-year-old child has intense pain in the abdominal area. He does not know where to turn.

Grace is 78 years old. She lives alone. She has several medical conditions, and is unable to pay for all of her medications. Grace is becoming more confused and frightened. She doesn't know where to turn or whom to ask.

Scripture tells us that "you always have the poor with you" (Mt 26:11). Tabitha, Tom, Mohammed and Grace are examples of the presence of the poor with us. Their stories are repeated thousands of times each day in the communities we serve. The presence of those who are poor does not decrease. It increases and intensifies in severity and complexity.

Environment and Heritage

Today's economy, global conflict, a litigious society, and pressures on all groups within the healthcare environment threaten to overwhelm both those who are poor and those who serve them. The current economic recession has resulted in an increasing number of uninsured and underinsured persons. The most recent statistic indicates that the number of uninsured Americans increased by 1.4 million between 2000 and 2001.¹

For the third year in a row, states are experiencing extreme economic problems and have been forced to struggle with federal reductions in Medicaid and Medicare. Most states are cutting spending on healthcare programs in attempts to balance their budgets. In addition to inadequate Medicare and Medicaid reimbursements, healthcare providers are faced with a number of financial constraints including shortages of healthcare workers, bio-terrorism preparedness, and the rising cost of technology and drugs. Skyrocketing medical liability

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insurance premiums have left some healthcare providers unable to secure affordable liability insurance. As a result of these financial constraints, some providers have been forced to curtail the services they provide or to discontinue practicing altogether. Unfortunately, this is occurring at a time when there are increasing numbers of individuals who cannot afford healthcare. When access to care is compromised, everyone is affected, but the uninsured and underinsured often have fewer options when their provider no longer accepts them as patients. When healthcare providers limit the number of uninsured/underinsured patients they see, they may save money initially. They may also see a dramatic increase in visits to their emergency departments and in the severity of those they treat.

It is within this environment that CHE declares that it holds “Justice” and “Commitment to those who are poor” as two of its cherished Core Values. “We give priority to those whom society ignores,” we say, and “We advocate for a society in which all can realize their full potential and achieve the common good.” We care about all who need us, but we care especially about Tabitha, Mohammed, Tom, and Grace. While we may always have those who are poor with us, we will never get used to their suffering. We will always work to lessen their number and alleviate their pain.

Why would we say these things? Why would we care so much? In the first place, healthcare is about service and about need. Healthcare responds to the needs of persons in birth, in all of life’s processes, in suffering, and in death. Were there no need, there would be no healthcare. Need called our ministry into being and need sustains it.

Secondly, almost all of human society recognizes the claim human need places upon people. In the world community – and to a large extent within the U.S. society – there is significant agreement that healthcare is a basic human right. The United Nations’ *Universal Declaration of Human Rights*, for example, includes medical care in its listing of basic human rights (Article 25).

Further, religious traditions, including the Catholic tradition, are unequivocal about the existence of a basic right to healthcare. Religious traditions recognize that along with food, housing, and access to education, access to healthcare is essential to the development and maintenance of human dignity.

As organizations within the Catholic tradition, the members of CHE are living witnesses to this recognition and the commitment it entails. We are inheritors of a firm belief that we are called to serve those who are most in need. We are also inheritors of a rich biblical tradition that speaks to us of God’s special care for those who are poor and most vulnerable. This tradition begins with the self-understanding of a people who have been specially chosen by God in their smallness and their slavery. The Israelites remembered that they were slaves when God chose to free them. They knew that it was not their greatness, but their need that called forth God’s love. “The Lord your God has chosen you out of all the peoples on earth to be God’s people, God’s treasured possession. It was not because you were more numerous than any other people that the Lord set heart on you and chose you – for you were the fewest of all peoples” (Deut 7:6-7).

The biblical story tells us of the prophets who spoke God’s words to the people. Their most frequent cries, their most fierce reprimands were reserved for those who forgot who they were and hence neglected the needy and vulnerable. When the people built great temples while ignoring the poor, the prophets roared. The prophet Amos, for example, declares that “the Lord roars from Zion” because the people “trample upon the poor” (Amos 1:2;5:11). God’s people knew themselves as a community beloved by God in their very need. They have also known themselves called to do for others as God had done for them – to care for and hold beloved those who are least, who are most vulnerable, who are poor.

Within the Christian tradition, Jesus is the clearest indication of both God’s predilection and our call to serve. Poor himself, he consistently reached out to those who were poor, those whom society ignored or would have liked to ignore. The Gospel of Luke tells us that Jesus began his work by declaring that he had been sent to “bring good news to the poor,” (Lk 4:18). The Gospel of Matthew goes even further when it tells us that Jesus identified himself with the poor when he called his followers to feed the hungry, clothe the naked, heal the sick. “Truly I tell you, just as you did it [feed, clothe, heal, etc.] to one of the least of these who are members of my family, you did it to me” (Mt 25:40).

We always have those who are poor with us and they are always a reminder of who we are called to be and what we are called to do.

Catholic social teachings remind us of this fact in all their documents. The Catholic Bishops of the United States frequently echo the prophets as they become the voice for those who have no voice. In their 1986 Pastoral Letter, *Economic Justice for All*, they stated: “The fundamental moral criterion for all economic decisions, policies, and institutions is this: They must be at the service of all people, especially the poor (Para. 24).² This “preferential option for the poor” requires not only a prophetic mandate to speak on behalf for those who have no one to speak for them, but also to see things from the side of the poor.³

In their most recent revision of the *Ethical and Religious Directives for Catholic Health Care Services*, the Bishops place care of those who are poor as one of the normative principles that inform the Church’s healing ministry: “...the biblical mandate to care for the poor requires us to express this in concrete action at all levels of Catholic health care. This mandate prompts us to work to ensure that our country’s health care delivery system provides adequate health care for the poor. In Catholic institutions, particular attention should be given to the health care needs of the poor, the uninsured and the underinsured.”⁴

The recent pastoral reflection of the U.S. Catholic Bishops, *A Place at the Table*,⁵ once again focuses upon the needs of those who are poor. This document offers several reasons to focus on these needs:

- our faith calls us to it;
- our nation needs it;
- our world requires it;
- our salvation demands it;
- our actions can make a difference.

In addition to our heritage of faith that calls us to care for those who are poor, CHE has been established upon the foundation of its Sponsors’ common commitment to serve those who are most vulnerable, who are marginalized and without power. When we speak of the charism or spirit of the Sponsors, we speak of the gifts they have received from their founders as well as the history that has shaped their experience. All the gifts and all the histories of CHE’s Sponsors witness to the same call: care for those who are poor, those who are most in need.

CHE’s *Vision 2010* describes the system we will strive to become. “As a community of persons, we are so compelled by our Mission, that CHE will

be recognized as a leader in innovation and relationships, committed to:

- Promoting wellness and improving health of persons and communities, especially those most vulnerable; [*underline added*]
- Developing and applying creative approaches to health ministry;
- Being an employer of choice; and,
- Effectively stewarding our resources.

In 2002, we embarked upon a Values in Practice (VIP) initiative. The VIP pillars of People and of Growth call for excellence in caring for people and in growth according to our values. Growth is not limited to numbers and size. It also means growth in living our mission and values, in caring for those who are poor.

Caring for those who are poor, then, is of the essence of who we are and what we do in the ministry of Catholic healthcare. Caring for those who are poor is also very difficult and becomes more difficult each day.

II. DEFINITIONS

In discussions of care of those who are poor, several terms are used and, depending on the context or the persons using them, these terms can have different meanings or nuances. It is important to be clear about the terms we use and the meanings we ascribe to them. The following definitions are the ones used in this work. It is recommended that they become the common definitions throughout the System.

Health. The World Health Organization defines health as “a state of complete physical, mental, social well-being, and not merely the absence of disease or infirmity.”⁶

Those who are poor. The Catholic Health Association defines those who are poor in terms of access to health care: “those persons unable through private resources, employer support, or public aid, to provide payment for health care services, or those unable to gain access to health care because of limited resources, inadequate education or discrimination.”

Those who are poor are found disproportionately with the following faces: uninsured and underinsured, children and unborn,

single heads of households – especially women of racial minorities in urban areas, the elderly, those with incurable diseases and chemical dependencies, racial minorities, immigrants and refugees. The faces of the poor will vary depending upon region, rural and urban areas, marital status, race, gender, age, and citizenship, to name a few characteristics.

Charity Care. Care provided at no charge or reduced charge to patients who are unable to pay for these services. It is a budgeted amount that is reported each month along with other budget items. Charity care is also reported as an element of the Social Accountability /Community Benefit process. When reporting the amount of charity care that an organization provides, there is general agreement that the cost of care, not the healthcare organization charges, is the most accurate report. Only the actual costs and not the organization’s loss of revenue are considered in our discussion of charity care. In some contexts, however, it may be necessary to cite both cost and loss of revenue for comparison purposes.

Bad Debt. As distinguished from charity care, bad debt is the unpaid costs of care from those persons deemed able to pay for their medical care. No charity care should be a part of the bad debt reporting.

Social Accountability/Community Benefit. Social Accountability /Community Benefit is the process of giving an account of the benefit that an organization gives both to those who are poor and to the community at large. This process is frequently done through the use of a computer software program, “Community Benefit Inventory for Social Accountability,” that enables organizational tracking and reporting of community benefit activities. Social Accountability/Community Benefit has two categories: quantifiable and non-quantifiable benefits. Quantifiable benefits include: charity care, unpaid costs of public programs, non-billed community services, cash and in-kind donations made by a facility, education of health professionals, research activities, subsidized services generating low or negative incomes, and community building programs. Non-quantifiable benefits include responsiveness to community needs of those who are poor and vulnerable, identifying needs, attracting and effectively using donated funds, encouraging volunteers, and advocacy.

Defining and quantifying the care for those who are poor is a complex undertaking. Not all that

we do in terms of benefit for the community, nor all the loss that we incur from unpaid costs for public programs is actual care of those who are poor. Many activities benefit the population as a whole. Some unpaid costs, such as those from Medicare patients, have little relation to the patient’s economic status and/or ability to gain access to care. An important challenge for us as we seek to understand how we are caring for those who are poor is to attain clarity around categories, reporting mechanisms, definitions, and both the goals and costs of specific programs.

III. CHE’S CARE FOR THOSE WHO ARE POOR

It is important for us to measure and give account for our care for those who are poor for two reasons. In the first place, the community demands it. As not-for-profit community based organizations, we are required to account for the benefits we provide to the community in exchange for our tax-exempt status. As faith-based organizations there is a more significant reason: we need to account to ourselves and to each other for our fidelity to our call to serve. We need to be aware of the consistency of our care, and the growth or diminishment in the scope of care we provide for those who are poor.

Within the complexity of definitions, demarcations and overlaps, two major aspects of care of those who are poor present themselves: advocacy and direct service. It is important to recognize that these two aspects of care act in tandem. Neither is sufficient, both support and reinforce each other.

Advocacy

Advocacy is an organized and focused effort to speak out for those whose voices often go unheard. Advocacy is a powerful and effective means of giving priority to those whom society ignores. It seeks to raise the consciousness of people, to affect public opinion, influence legislation, ameliorate the conditions of those in need.

Advocacy takes place on the national level where it seeks to be an influence in policy discussions and legislative activity. It also takes place at the local level through consciousness-raising and involvement of persons within our ministry in attempts to influence the actions of elected officials through communications from the electorate. CHE has 43,000 persons who share in this ministry. These persons can be – and are – a significant voice for the voiceless. They can raise local issues and promote

initiatives that otherwise might never be realized. Together, members of CHE have advocated effectively for CHIP (Children's Health Insurance Programs) and its implementation at the state level (SCHIP), adequate Medicaid and Medicare reimbursements, tort reform, restoration of state Medicaid expansion programs, and Community Access Programs.

In order to be effective within these two arenas and to unleash the potential of the system, CHE established an Advocacy and Government Relations department. This department functions primarily to manage, coordinate, and implement CHE's system-wide advocacy program. The department serves as CHE's point of contact with key legislative and regulatory stakeholders, and works collaboratively with the RHC/JOAs regarding the development and implementation of local, regional, statewide, and national advocacy activities.

CHE's 2002 advocacy agenda set out a road map concerning how the system would work to advocate for individuals who are poor or underserved. Throughout 2002, CHE worked in collaboration with other Catholic health systems, the American Hospital Association, the Catholic Health Association (CHA), Premier, and the Children's Health Matters Coalition to advocate for broader coverage for uninsured populations as well as to make it easier for individuals to enroll in existing public health programs. Additionally, the department worked successfully in coalition with other Catholic health systems to get the Community Access Program (a federal grant program that funds local community collaborations which focus on addressing the unmet health care and social service needs of vulnerable populations) authorized in the Public Health Services Act.

Additionally, in 2002, for the first time, CHE engaged in an advocacy initiative aimed at garnering federal appropriations funds for RHC/JOA specific projects. Early in 2003, Congress approved its appropriations bills, resulting in four of CHE's Regional Health Corporations/Joint Operating Agreements (RHC/JOAs) receiving in excess of \$1.4 million to support four projects aimed at improving access to needed health care and social services for poor and low income individuals. (See Appendix A)

Direct Service to Those Who are Poor

The Gospels provide us with accounts of the deeds of Jesus. They tell us what he did and how he did it. Sometimes he touched and healed a person who came to him or was brought to him by others. Sometimes he sought out a person that others would have liked to ignore. Always the words he used pointed to the needs of the people, to our tendency to be blind to needs. The words of Jesus always call us to transformation.

In very real ways, advocacy echoes the words of Jesus and his ministry of speaking God's vision for the community. The direct service we provide mirrors the actions of Jesus. When we welcome and treat with reverence those who come to us or are brought to us – even though they have no means of support – we make visible Jesus' love for those who are poor. And when we reach out through programs, clinics, and collaborative efforts, we mirror Jesus' willingness to reach out to those others would just as soon forget.

Direct service is the actual, concrete, day-to-day service that is provided to persons who are poor. This service takes place in two ways. We care for those who come to us (our charity care), and we reach out to those who could be lost (our outreach programs, clinics, collaborative services).

Charity Care. In 2002, at CHE, the provision of charity care cost \$62,215,000. This amount equates to 1.85% of the total expenses of the system, and 1.84% of the total revenue. It also represents 155.95% of the system's operating income (\$39,896,000). Further, the 2002 amount is an increase of 31.9% over the 2001 total of \$36,569,000. The budgeted number for 2003 is \$53,923,000.

Two aspects of the system's charity care services call for further reflection: budgeting for charity care and charity care policies. When annual budgeting is done and the charity care amounts are determined, it is important to ask ourselves whether we approach the charity care number in terms of what we must do or what we want to do. Do we ask ourselves how we can increase this number or do we worry that it might increase? How integral, how important – as a goal - to the budgeting process is the importance of our charity care? Are there ways we can be innovative in this regard?

Each organization within CHE has a charity care policy that deals with eligibility, procedures, and processes. An examination of these policies shows that there is a great variety of criteria for determination of eligibility, processes for application, procedures for approval, public notification of the policy, and even of the meaning and purpose of charity care itself. There is a need to examine the existing policies and to revise them as necessary.

Outreach Programs and Services. Even as we can never ignore the person that stands before us, so too, we are part of a heritage that has always reached beyond itself to serve those in need. The amount of charity care that is provided by our organizations is substantial. It in no way represents the totality of our service. The following overview of our outreach programs and services gives us a fuller picture of what we do. The picture they provide is one that makes us proud and grateful. It reflects fidelity to the spirit of our founders even as it provides living witness to God's predilection for those who are most vulnerable.

CHE's RHCs/JOAs are engaged in a variety of programs whose goal are to provide health and social services to poor and underserved individuals. Whether through the provision of direct services or through collaborative relationships, the approach and strategy varies and is dependent on an organization's patient mix, the healthcare marketplace in which it resides, and the unique geographic nature of its service area. The programs highlighted in the following paragraphs are only a small sample of CHE's programs aimed at caring for poor and underserved individuals.

One strategy prominently represented System-wide is the care for those who are homeless. **Healthcare services for the homeless** are provided by a number of CHE's RHCs (Saint Joseph's Health System, Atlanta, GA; Pittsburgh Mercy Health System, PA; Lourdes Health System in Camden NJ; Sisters of Providence Health System in Springfield, MA; Mercy Community Health, West Hartford, CT' and St. Peter's Health Care Services, Albany, NY) These programs address the problem of homelessness from a multi-disciplinary approach to deliver care to homeless persons by combining aggressive street outreach with integrated systems of primary care, mental health and substance abuse services, case management, client advocacy, and the provision of transitional housing. In particular, these programs place a high level of emphasis on partnering and

coordinating efforts with other community health providers and social service agencies. Mercy Health System of Maine, Portland, ME, through the McAuley Residence has focused on a subset of the homeless by providing transitional housing for displaced woman and children.

Another strategy prominently represented System-wide is the focus on the provision of **pediatric services** to poor and underserved individuals. For example, Mercy Children's Medical Center's (Pittsburgh Mercy Health System) community programming provides health services to poor and underserved youth who reside in some of Pittsburgh's most impoverished and disadvantaged communities. Additionally, Sisters Hospital School Based Health Program (Catholic Health System, Buffalo, NY) provides comprehensive health care services at two elementary schools where students reside in communities that are medically underserved with a predominately low-income population and high unemployment. One other example is St. Francis Medical Center's (Trenton, NJ) Angel's Wings program which provides around the clock emergency and respite care for displaced children until they can be reunited with their families or placed in appropriate foster care.

CHE's RHCs/JOAs are also active in implementing **community health care projects** whose goals are to provide direct services to poor and underserved individuals. Whether it's engaging in collaborative community partnerships, setting up health centers, or providing financial support for existing programs, the RHCs and JOAs have implemented various strategies to address the problems of the poor and underserved. For example, Morton Plant Mease Health Care's Turley Family Health Center (Clearwater, FL) provides comprehensive health care for adults with limited income and no insurance or access point to the health care system. St. Mary Medical Center, Langhorne, PA, has provided leadership in establishing the Bensalem Ministries, a collaborative community partnership, that provides a continuum of care to the poor and underserved in Lower Bucks County through the Mother Bachmann Maternity Center, the St. Mary Children's Health Center, and the St. Mary Family Resource Center. Another example to note is the St. John Bosco Clinic in Little Havana, Miami, Florida. St. John Bosco is sponsored by Mercy Hospital, and provides diagnostic and outpatient services at no cost to patients, all of whom are indigent, uninsured and otherwise without access to

healthcare. A key component of Mercy Medical's Hospice Program (Daphne, AL) is the provision of home care hospice services, with particular emphasis on providing assistance to those who otherwise could not afford such services. Finally, Lourdes Health System, Camden, NJ, operates the Osborne Family Health Center which provides services to low income and medically indigent populations in Camden, NJ, a city where there is a high incidence of infant mortality, perinatal mortality, low birth weight deliveries and teenage pregnancies. The Osborn Family Health Center is a licensed ambulatory health care facility providing comprehensive Obstetrics, Gynecology, Pediatrics and Family Practice care to more than 45,000 patients each year, including the delivery of more than 1000 babies.

CHE's RHCs/JOAs have also identified a need and implemented programs to provide services for **poor and underserved seniors**. St. Joseph of the Pines' (Southern Pines, NC) Providence Place provides needed, affordable housing for senior adults. Mercy Uihlein Health Corporation (Lake Placid, NY) collaborates with other organizations to provide chronic health services for persons and families who are poor. Another example is St. Agnes Medical Center's (Philadelphia, PA) Living Independently for Elders (L.I.F.E) program which provides all-inclusive community-based, long-term care to elders who need nursing home level of care and are living in their own home in the community. Because of the LIFE program's service area, individuals in the program tend to be low-income seniors who, under other circumstances, would be admitted to a nursing home and forced to leave their homes and families. Additionally, CHE is also an active partner in the Mercy Housing Organization whose mission is to establish quality affordable housing to low-income and poor individuals.

The provision of **behavioral health services** is another area where CHE's RHCs have identified a community need and implemented programs. For example, Sisters of Providence Behavioral Health Care, Holyoke, MA is the largest provider of mental health and substance abuse services to the poor, ethnically diverse communities of Western Massachusetts. Another example is the St. James Mercy Health System's Mercycare Alcoholism Treatment Center of Hornell (MATCH) (New York) which provides quality care aimed at promoting addiction recovery services particularly for poor, underserved and disadvantaged individuals.

CHE's System-wide commitment to care for the poor is not solely focused on the provision of health care services. Many organizations within CHE take a holistic view when seeking to serve poor and underserved populations and look to provide **other services**. For example, the Osborne Family Health Center in Camden, NJ, provides their patients with books and other goods such as clothing and shoes. Another example would be the Food Pantry Partnership Program at Holy Cross Hospital, Ft. Lauderdale, FL, which through creative campaigns, organizes and facilitates a community effort to collect food items for the local food pantries.

CHE's RHCs and JOAs have also identified the benefits of establishing **community-based** partnerships or collaborating with other organizations to address the needs of the poor and underserved. For example, Allegany Franciscan Ministries, Tampa, FL convenes regular meetings of community partners to facilitate collaboration around issues concerning poor and underserved individuals. Recently, they held their second Hispanic Summit in Pinellas County, Florida to identify needs of the respective communities. St. Mary's Health Care System, Inc. (Athens, GA) actively participates in the "Peach Care for Kids" program by sponsoring bilingual counseling sessions and full-time assistance in enrolling children in an affordable health insurance coverage programs.

Global Health Ministry works collaboratively with a number of organizations to: provide cross-cultural healthcare, support healthy community development, and transform the providers as well as the recipients of care and the communities in which they live. Global Health Ministry sends teams of healthcare professionals to provincial villages and distressed urban areas in Latin America and the Caribbean to help people with little or no access to professional healthcare.

Additionally, four RHCs/JOAs are active participants in Community Access Program coalitions: St. Francis, Wilmington, DE; Catholic Health System, Buffalo, NY; Sisters of Providence Health System, Springfield, MA; and St. Joseph's Health System, Atlanta, GA. The purpose of the Community Access Program is to assist communities and safety net providers in developing the infrastructure necessary to participate in integrated health systems and coordinating care for poor and underserved individuals.

Numbers can impress us; names of programs can intrigue us. What is important is that the preceding numbers and programs represent thousands of persons like Tabitha, Grace, Mohammed and Tom. CHE serves thousands of persons who are poor. We can be grateful that our mission and our values are visible in our service. It will always be a challenge to give an account of this service, yet such an account is required – for the communities in which we serve and for our own integrity.

The Social Accountability/Community Benefit Process. As we have seen in the section on definitions, one of the ways we account for our service to those who are poor is through completion of the social accountability budget. The Catholic Health Association developed the Social Accountability Budget Process over ten years ago to help ministry leaders plan for, administer and report community benefit. The process helps organizations quantify their care for uninsured and underserved persons. It also accounts for the cost of other initiatives that increase the financial value of the unreimbursed services that organizations provide for their communities.

Since assessment of an organizations' community benefit requires accurate data collection and reporting, CHA partnered with several other health organizations and the Lyon Software company to develop a software program (Community Benefit for Social Accountability) that enables organizational tracking and reporting of community benefit activities. CHE member organizations began utilizing this program in mid-2000. Monthly reporting processes were established by year-end 2000. Since then, improved consistency and reliability of data have been evidenced throughout the system.

A true community benefit is provided primarily as a service. Services that are included in the inventory generally: result in a financial loss to the organization and require some sort of subsidization; are quantified in terms of dollars spent or numbers of persons served; and have an explicit organizational budget.

An important distinction that is made in quantifying social accountability/community benefit is that of identifying which services are solely for those who are poor and which services benefit the greater community. The criteria used to identify services for those who are poor include: most of the

program users are poor (e.g.: those at 150% or lower of the federally defined poverty level); most are beneficiaries of Medicaid or state or local programs for the medically indigent; the program is designed to reduce morbidity and mortality rates (e.g.: low birth rates) caused by or related to poverty; and/or the program is physically located in and attracts most of its participants from a site identified as medically underserved.

Accurate social accountability/community benefit reporting requires clarity of definitions for inventory categories and close scrutiny with regards to their interpretation.¹ Many people are involved in the compilation of the social accountability/community benefit report. It is important that good oversight be provided and that there is ongoing study of the reports to ensure the best possible accuracy.

In 2002, CHE provided social accountability/community benefit services and activities to over 3 million people, representing an aggregate net community benefit cost of approximately \$359,000,000. Of the \$359 million, over \$62 million was direct charity care, the unpaid costs of Medicaid amounted to \$83.5 million, and the cost of other public programs for those who are poor was almost \$4.5 million.

The wide range of community benefit provided by CHE member organizations has helped to transform the communities we serve by providing quality health services regardless of ability to pay, increasing access to health care resources, promoting community-based screenings for early disease detection, advancing health and wellness education, assisting community agencies in promoting healthy communities, improving health care through research activities, and training competent and compassionate health professionals.

While the social accountability/community benefit program provides us with a broad picture of the scope of our activities, it is not without its problems. The following questions and challenges need to be addressed:

- Do social accountability reports reflect and substantiate commitment to and priority for those who are poor?
- Do community benefit services respond to community needs?
- How do advocacy efforts relate to community benefit services?

IV. MAKING GOOD DECISIONS

Caring for those who are poor will not get easier. The poor are always with us, and their numbers increase daily. The number of uninsured rises and the number of unemployed grows. Malpractice costs and lower reimbursements are leading many physicians to withdraw from active practice and/or to refuse to care for persons who are unable to pay. State cuts in Medicaid threaten to be draconian, and those who are poor will suffer the most. Within this context, we find ourselves challenged to become more creative, more collaborative, more intentional, more discerning in our efforts. An important commitment grounds our decision making: reducing care for those who are poor is never the first reaction to financial tensions. Any reduction in such care comes only after long and careful reflection.

Needs Assessment and Evaluation

The founder of one community of women religious once declared, “I desire to be everywhere when I see so many needs.” One of our greatest difficulties lies in our desire to “be everywhere” in serving the need of our people. We know we cannot do this. How, then, do we decide? One way is through a comprehensive and focused needs assessment.

A needs assessment is a process that involves studying the demographics of the served population, discerning trends within both healthcare and the community, discovering the major health problems that are present, the areas that are un- or underserved, the resources that are available, and opportunities for collaboration with others. A needs assessment helps us to accurately see our community. A comprehensive one includes careful listening to those whom we seek to serve, especially those who are poor and underserved. The poor are always with us, and it is they who must tell us what they need and how they need it.

CHE’s System policy #200, “Planning, Budgeting, and Capital Project Approval,” describes the process for the development of an organization’s strategic plan. This plan is to be accomplished every three years and is to include a needs assessment. The assessment can provide information about increasing market share, and enhancing services. It can also help us to find ways to better serve those who are poor. Even as a needs assessment can help us to recognize emerging and/or unmet needs, an

evaluation of existing programs and services can help point out what is being done well, what may no longer be needed, what is being done well by others, and what can be enhanced through greater collaboration. Organizations are wise to continually evaluate their ongoing services in order to ensure their effectiveness and timeliness.

Sometimes, neither a needs assessment nor an evaluation will make difficult choices easy. We need a way to walk through decisions and to ensure as best we can that our choices are in accord with reality, our mission, and our values. The following “Process for Decision Making” provides a vehicle for making good decisions in a difficult context.

CHE has had a values-based decision making model for several years. The following process builds upon that model, modifies it, streamlines it, and applies it to a particular issue – caring for those who are poor. This model, however, can be used as a basic tool for decision making around any significant issue, and can replace the existing process.

A Process for Decision Making

CHE’s commitment to persons who are poor, as well as its experience of the limits that today’s environment creates, makes it necessary to periodically review programs and services for the neediest among us. CHE institutions can do this at different times, including strategic planning, annual preparation of the budget, review of social accountability reports, and when faced with choices to open or close individual programs and services. To make the best possible decisions, it is important to use a process that is comprehensive, fair, and consistent with the mission and values of CHE. Decision makers, in the face of limited and competing resources, will be forced to balance maintaining financial stability with caring for persons who are poor. These decision makers will be held accountable and be expected to explain the decision and reasons for the decision to trustees, sponsors, colleagues, and the community. The process described below is a tool to help decision makers thoroughly examining all aspects of these often difficult decisions. The process and questions are a means for decision makers to make explicit and transparent the values that were in conflict and the values that guided the final outcome. It will provide assurance and comfort that the best possible decision has been made.

Each time an organization faces the choices about care of persons who are poor, it should move through three stages of the process:

- Preparation,
- Decision,
- Follow through.

Phase 1: Preparation. Before beginning a reflection on an organization's care of poor persons, there needs to be consideration of what kind of structure is needed to carry out the reflection. The greater the complexity of the issue and the larger the community of concern, the greater the infrastructure needed. In the preparation phase, those responsible for planning should make estimates about the following categories:

Low → High

Number of persons/groups impacted

- Duration of the impact
- Depth of impact
- Closeness to institution's mission
- Degree of complexity
- Past commitments
- Relationship to strategic direction

Further, those responsible for the preparation should determine who needs to be involved in the process. Who belongs to the community of concern that will do justice to the issue's height/weight.

- Based on the nature of the issue: What other groups – both outside of and within the organization - need to be part of the process?
- What is the nature and frequency of their connection to the issue?
- What departments within the organization will be affected?
- What departments might have insight?
- What other entities will be affected by the decision?
- Who would have insights to the Mission and tradition as it applies to this decision?

Phase II: Decision. The following steps help to focus and harness the complexity of the issue and the community of concern.

1. Pray, reflect, restate question, and clarify authority.

Decision makers should prayerfully reflect on those who are poor, the faces of those in the service area, and determine that the services to them

treat them not as poor but as brother and sister. Then the decision makers should restate the choices and moral question and seek to arrive at a functional consensus about these. After agreement is reached about the scope of the choices and the moral question, those making the decision should clarify who will make the final decision and who needs to be involved in the decision making.

2. Determine primary/secondary communities of concern, their interests.

The decision makers, having identified the community of concern to be affected by the decision in Phase 1, should then identify these communities' interests. For example, what is of value to the primary and secondary communities and how will they be affected by the decision? What values will be promoted by opening or expanding services or programs and what values will be threatened by limiting or closing a service or program?

3. Gather and confirm needed information, data.

This step requires a health needs assessment of the local population which includes the identification of how and where those needs are being met. The needs assessment developed for an institution's three-year strategic plan is a crucial source for information about care for those who are poor. This needs assessment may be augmented with national, state, and local needs identification, for instance the U.S. Public Health Department *Healthy People 2010*.

- What are the demographics of poverty in the institution's service area?
- Who are the underserved?
- Who are the disenfranchised?
- In your service area what is the population of the following: single women with children, homeless, immigrants, undocumented persons, the elderly, persons with disabilities, mental illness, and substance abuse?
- What is the overall health status of the population served?
- Who are the people that are identified currently
- In programming as poor? By what criteria are they determined to be poor? Are there persons who are poor by other standards who ought to be included?
- Are there any programs that disproportionately burden the poor? (e.g., requiring self-pay patients to pay the full

amount and not the discounted rate offered to the insured).

- What are the existing programs that care for poor persons at the institution? What are the existing programs for poor persons in the community?
- How does this information compare with the data gathered in the social accountability/community benefit reporting?

4. Identify key value/moral commitments and conflicts among these.

- What core values are most strained by care of the poor?
- What is the historical institutional commitment to different populations?

5. Establish priorities among goals, commitments, values.

Setting priorities should commence with a reflection on moral and institutional commitments. A pre-established list of priorities does not exist, but after reflection, and an investigation of the key questions below, decision makers can discern priorities in a democratic manner. Priorities are best set by looking at the needs from a strategic perspective. Among the questions that require reflection are:

- Are all programs/services being evaluated on their ability to meet the strategic goals or are only some being singled out for reductions and expansions? Has the evaluation of what programs/services to open or close been applied across the board or are only certain ones singled out?
- Should priority setting focus on new programs/services only or existing ones as well?
- Does the programming focus on the needs of the poor of the population or needs of individual poor persons?
- Does the programming focus on the broad definition of health, the prevention of disease, the cure of disease, or the alleviation of suffering?
- Has the proposal for priorities identified and eliminated health care services that have been demonstrated to be useless, safely foregone, or are only marginally beneficial?
- Are the limited resources distributed on a first come, first serve basis? If so, is there a way to assure that the vulnerable and poor have equal chance at accessing the service?

- Has the institution identified basic services that should be provided before additional services will
- be provided? Has the institution evaluated those essential services in light of public health goals (such as those articulated in *Healthy People 2010*)?
- Is there a priority between direct service and advocacy?
- Have the worst off among the poor been given priority before other poor persons have been provided services? For example, have persons who are severely and persistently mentally ill been cared for before those with less severe mental illness?
- Priority setting requires that the voices of all who are affected be heard. Has the decision making process been conducted in a transparent manner and have all the voices been accounted for?
- Has the priority setting process set up a method to continuously identify and evaluate the effect of the services provided on those who are poor?
- After priorities have been set, is there an appeals process to consider those cases where priority setting has excluded services?
- Has the institution investigated whether the costs of the service can be diminished by collaboration or funding partnerships, such as government subsidy and grants?

6. Develop options that address identified priorities.

7. In silence reflect, then listen to viewpoints.

8. Gain consensus on the decision.

Phase III: Follow Through

- Develop an Implementation Plan Allocate Resources
- Assign accountabilities to specific persons for each component to be realized
- Design methods to monitor and report, including quantifiable metrics
 - Does the Social Accountability report accurately reflect and distinguish the institution's care for persons who are poor?
- Build communication plan with key publics, and messages

- Since it is important to connect meaning and purpose in the workplace, have the employees been informed of the institution's commitment to poor persons through stories of the programs and services?
- Build a celebration plan that honors persons who have cared for the poor and tie it to mission with its central commitment to care for those who are poor.

V. CONCLUSION

CHE was formed out of a desire to serve. It represents the passion of its sponsors to care for those who are in need, especially the most vulnerable, those who are poor, those whom society ignores. CHE lives today in the passion and dedication of the thousands of women and men who serve within its organizations. Our colleagues in ministry are living and vibrant witness that someone cares, that God cares. We are blessed to serve in this ministry. We are graced to share it with so many whose example inspires our own commitment. Reflections over the past decades have led many to recognize once again that God is present in the everyday-ness of our lives. Further reflection has shown that God's presence is made visible for us (we can see it and hear it) in the people and the actions that occur in God's name and with God's love. When we care for our brothers and sisters, especially those who have no one else to care for them or who are despised and disregarded by society, we become like the One of the gospels. We serve as witness, presence, as more than we are alone. At these moments, CHE lives its integrity. We are who we say we are. We become a community of persons committed to being a transforming, healing presence in the communities we serve.

The poor are always with us. They are call to us and judgment upon us. They are also a blessing, for in serving persons such as these we are ourselves transformed. Those who are poor are always with us and they always teach us. For this we must be grateful.

VI. FINDINGS AND RECOMMENDATIONS

1. Caring for Those Who Are Poor – Reflection and Discussion

Finding: Caring for those who are poor is of the essence of who we are. While it may feel like a

burden at times, the opportunity to serve those who are poor is gift. Time needs to be given to reflection and discussion of this essential aspect of our ministry.

Recommendation: The discussion/reflection questions at the end of *Always With Us*, and the prayer/reflection process, "Who Will Speak" should be used to further discussion of care to those who are poor. The document, the discussion questions, the reflection process are to be used with System and RHC Boards and Senior Management. They are especially important at times of budgeting and strategic planning.

2. Service of Those Who Are Poor – Diversity and Inclusion

Finding: The demographics of poverty point out the importance of recognizing diversity and creating a culture of inclusion in our service of those who are poor.

Recommendation: Each CHE organization needs to examine how its efforts to increase diversity and build a culture of inclusion are related to and enhanced by its programs and services to those who are poor.

3. Clarity of Definitions and Accountability

Finding: There is a need for clarity and integrity in our descriptions of how we serve the poor, and how we account for this service.

Recommendation: All of our organizations will use the definitions provided in "Always With Us," and will report provided services in terms of financial expense (cost) to the organization. If necessary, both expense and revenue will be recorded.

4. Charity Care Goals

Finding: Consistent and careful attention needs to be paid to each organization's targeted goal for charity care. A striving for growth in our provision of charity care should be our goal.

Recommendation: Careful oversight of charity care goals be maintained, and the system will strive to grow in this area. The 2002 amount of charity care will serve as a baseline against which to measure our growth.

5. Charity Care Policies

Finding: There is significant inconsistency in the format, scope, oversight of charity care policies within the system.

Recommendation: Each organization will review its charity care policy, revise it where necessary, and obtain its Board's approval. The following elements should be contained in any charity care policies:

- a statement of the organization's commitment to caring for those who are poor
- a values-based rationale for this policy
- the criteria for determining eligibility including reference to the state's determination regarding percentages of/above the national poverty level, and the organization's determination
- a reiteration of the system definitions of what is meant by:
 - those who are poor
 - charity care
 - bad debt
- procedures for administration of policy, approval of requests, review, evaluation
- indication of where administration of the policy is located, and who has responsibility, preferably in a collaborative effort between the Mission Executive and the Chief Financial Officer
- approval and reporting processes for local Board oversight and system accountability
- where and how the policy is published and posted

6. Social Accountability/Community Benefit Process

Finding: There is a need for greater clarity and dedicated oversight of the social accountability/community benefit process.

Recommendation: The system will continue to work toward greater clarity of definition and scope of community benefit reporting. Responsibility of the oversight for this reporting will be designated as located within the senior management of the organization, preferably with the CFO and the Mission Leader. As with other significant reports, the CEO of the organization will also attest to her/his confidence in the accuracy of the annual report. The annual amount of Social Accountability/Community Benefit for the organization will be at least equal to the estimated tax benefit allotted by the state.

7. Needs Assessment

Finding: A comprehensive needs assessment is vital to sustain our effective service to those who are poor. To best ascertain the needs of the community, it is important to speak with and learn from the community members themselves.

Recommendation: A comprehensive needs assessment will be done by each organization as an integral part of the development of its three-year strategic plan. This needs assessment will include conversations with community members and groups – especially those who are poor – to determine the needs of the persons we serve.

8. Evaluation of Programs and Services

Finding: In order to achieve excellence in our service to those who are poor, it is necessary to continually evaluate the quality and effectiveness of our programs and services.

Recommendation: Existing programs and services for those who are poor will be evaluated on an ongoing basis. These evaluations will include measuring the effectiveness of the program or service, its continued need, and opportunities for collaboration.

9. Values-Based Decision Making

Finding: A values-based decision making process is a necessary tool for making difficult choices with fidelity and integrity.

Recommendation: The decision making process outlined in this document will be used by those who are making any major decisions concerning care of those who are poor. Its effectiveness will be evaluated, its use documented and shared with the organization's Board and with other members of CHE.

VII. QUESTIONS FOR DISCUSSION

An issue such as caring for those who are poor can remain an "issue," a problem to be solved, something unrelated to our own lives unless we can relate it to our own experience and to the meaning of our work. The following questions are suggestions for further discussion among groups, with co-workers, as sources for Board reflection and for personal reflection. They relate to each of the sections of *Always With Us*. Hopefully, these questions will lead to further reflection on what must be an ongoing source of thought and commitment in our own lives and in the work that we do.

Why We are Concerned:

1. How have I experienced the increased difficulties of caring for those who are poor that are part of the healthcare environment today?
2. How has our organization experienced these difficulties? What have we done about them?
3. Who and what are the reminders of our heritage of commitment to those who are poor? How have they influenced my own work?

Definitions

1. What does the term “charity care” mean to me? Is it a positive term or a negative one?
2. How is the term used in our organization?
3. What has our organization learned about caring for those who are poor from its use of the Social Accountability/Community Benefit reporting process?

CHE’s Care for persons who are poor

1. How have I been involved in advocacy efforts? How have I been influenced by advocacy efforts?
2. Which programs/services that our organization provides make me proud to be connected with this organization?
3. What is my own experience of being with poor persons? How has that experience changed me?

Making good decisions:

1. What is one difficult decision that our organization has faced in serving those who are poor? How did we make that decision?
2. When I need to make a difficult decision, what is most helpful to me? Do I take the time to reflect upon the information, to recall why I am doing what I do?
3. How often does the organization involve stakeholders from the community in discussions about care for those who are poor? How often do I do this?

Conclusion:

1. Do I ever think that I can make God’s love visible to those I serve and those with whom I work? Has anyone ever made that love visible to me?
2. Who are those whose need calls to me and to our organization?

3. Is there blessing in our care of those who are poor? What is it?

Endnotes

¹ U.S Census 2000, *The Current Population Survey*, September 2002.

² United States Conference of Catholic Bishops, *Economic Justice for All: Pastoral Letter on Catholic Social Teaching and the U.S. Economy*, par. 24.

³ Such perspectives provide a basis today for what is called the “preferential option for the poor”. Though the Gospels and in the New Testament as a whole the offer of salvation is extended to all peoples, Jesus takes the side of the most in need, physically and spiritually. The example of Jesus poses a number of challenges to the contemporary Church. It imposes a prophetic mandate to speak for those who have no one to speak for them, to be a defender of the defenseless, who in biblical terms are the poor. It also demands a compassionate vision that enables the Church to see things from the side of the poor and powerless and to assess lifestyle, policies, and social institutions in terms of their impact on the poor. It summons the Church also to be an instrument in assisting people to experience the liberating power of God in their own lives so that they may respond to the Gospel in freedom and in dignity. Finally, and most radically, it calls for an emptying of self, both individually and corporately, that allows the Church to experience the power of God in the midst of poverty and powerlessness. *Economic Justice*, par. 52

⁴ United States Conference of Catholic Bishops, *Ethical and Religious Directives of Catholic Health Care Services*, p.6.

⁵ United States Conference of Catholic Bishops, *A Place at the Table: A Catholic Recommitment to Overcome Poverty and to Respect the Dignity of All God’s Children*, pp. 2-4.

⁶ World Health Organization, Preamble to the Constitution of the World Health Organization.

⁷ An example of this can be an organizations interpretation of “health promotion” services. Health promotion services designed to increase market share are basic services that might be provided by any organization (executive fitness programs for cardiac patients or prenatal classes for private patients, for example). These should not be reported as community benefit.



APPENDIX A

CHE's 2003 Federal Funding Strategy

Results

In 2002, CHE contracted with a government relations firm to assist us in our federal advocacy efforts. One component of our 2002 strategy focused on ways to draw down federal funding to support key programs/initiatives. Listed below are the programs that will receive funding in 2003, due to our efforts in 2002.

**St. Joseph's Mercy Care Services (SJMCS)
Atlanta, GA
Health Screening Program for Breast and Cervical
Cancer (BCCP)
\$350,000**

Since its inception in 1995, the goal of SJMCS' BCCP has been to increase access to early detection and treatment of breast and cervical cancer by providing a continuum of care. The BCCP was developed to address the cultural and economic barriers to primary care faced by all low-income women, including linguistic barriers encountered by immigrants and refugees.

The program builds upon the SJMCS model of care by using community-based mobile and fixed sites to conduct education and screening programs. The BCCP is the only community-based, culturally appropriate breast and cervical cancer health education and outreach program serving low-income women in metropolitan Atlanta. Featuring a multi-lingual staff, the program targets communities with a significant number of African-Americans, Hispanic immigrants, and Vietnamese refugees.

Although SJMCS currently provides primary medical services at 20 locations throughout metropolitan Atlanta, and offers outreach to street bound persons through various other programs, there are many additional opportunities for screening services to which it is currently unable to respond.

The cervical component of the BCCP is the most undeveloped part of the program. The program does not have the capacity to conduct colposcopies for clients. Clients are referred to outside agencies with which SJMCS has partnered to provide this service at a reduced fee. The current cost of a colposcopy is approximately \$700-\$1,200 and is not affordable to most of SJMCS' patients, who therefore do not seek follow-up treatment. This lack of follow-up treatment to diagnose and treat suspicious abnormalities that might be identified by a colposcope is a major deficiency of the program.

**Catholic Health System, Buffalo, NY
Our Lady of Victory Senior Neighborhood
Project
\$702,000**

The City of Lackawanna lacks adequate resources for its aging population. It lacks sufficient long-term care beds, assisted living facilities, senior citizen housing and other services for the elderly. With a declining population base, the demand for acute care hospital services has also declined. Over the last several years, Catholic Health System has closed most services at Our Lady of Victory Hospital (OLV). Although the need for acute care services has declined along with the population, as the city's population ages, the need for non-acute health care services and assisted housing for the elderly has increased and will continue to increase over the next 10 years.

By re-using the nearly vacant Our Lady of Victory Hospital campus, Catholic Health System can supplement existing resources and services to the elderly at a lower cost. In addition, utilizing the nearly 300,000 square feet of space available in the five buildings on the Our Lady of Victory campus allows the elderly to receive a continuum of care, from basic services to assisted living to skilled nursing care, at a single site.

The Neighborhood for Senior's will provide:

1. An 84 bed Skilled Nursing Facility – transferring existing SNF beds from a hospital facility to a residential environment
2. Assisted living and enriched housing linked to health care support services – giving priority to those with defined health care needs (25 apartments.)
3. An Alzheimer's disease care unit and assisted living apartments (15 apartments)
4. Senior housing for low to moderate income seniors – working in partnership with Mercy Housing Inc. and/or Delta Development (Catholic Charities Housing Developer) (46 apartments)
5. A Program of All Inclusive Care to the Elderly (PACE) – Catholic Health System currently holds a NYS license to operate a PACE site and is currently discussing joint sponsorship of the program with other health facilities in the area
6. Geriatric Primary Care Services - providing services to several hundred new elderly patients
7. Meals on Wheels – utilizing the OLV kitchen to prepare the food for the Lackawanna Meals on Wheels program allows the program to lower costs and increase the number of elderly served
8. Respite care for seniors caring for loved ones (5 respite beds)
9. On-site physician offices to serve those living on and near the campus

**Mercy Miami - St. John Bosco Clinic
Diabetes Educational Program
\$233,000**

The proposed diabetes educational program would assist in providing early detection and treatment services. A certified diabetes educator is prepared to provide the full array of education necessary to the diabetic patient. A core Curriculum would include a

four-hour session at the time of diagnosis, with a follow up group session at the 3-month, 6-month and 12-month intervals after diagnosis. Follow up is a critical part of this program. Many of the patients seeking services at the clinic do not have established or routine relationships with the health care system, and the clinic does not have the resources to record the necessary patient data and follow up visits with patients.

**Pittsburgh Mercy Health System
Pediatric, Adolescent, and Parenting Health
Initiative
\$200,000**

Pittsburgh Mercy Health System will receive \$200,000 to provide and expand outreach and health care services to indigent children, adolescents and their parents in two low income communities and through adolescent wellness centers.

Green Meadows (an 1100-unit rental housing community located in Baldwin, a suburb of Pittsburgh) is in large measure rented under a subsidized housing program. St. Clair Village (a public housing community located in the city of Pittsburgh, on the South Side slopes) is a health professional shortage area and a community undergoing a rapid transformation. Adolescent Wellness Centers are an integral part of Mercy Health System's network. Through free standing health centers and schools, Mercy Health System provides programs to address teen pregnancy and sexually transmitted diseases, teacher education, and parental education.



APPENDIX B

ALWAYS WITH US: A REFLECTION

Select an appropriate musical reflection. One suggestion is:

MUSIC – Who Will Speak? (Marty Haugen – “Agape”)

Who will speak for the poor and the broken? Who will speak for the peoples oppressed?
Who will speak so their voice will be heard? Oh, who will speak if you don’t?

Refrain:
Who will speak if you don’t? Who will speak if you don’t?
Who will speak so their voice will be heard? Oh, who will speak if you don’t?

Who will speak for the ones who are voiceless, speak the truth in the places of power?
Who will speak so their voice will be heard? Oh, who will speak if you don’t? (Refrain)

Who will speak for the children of violence? Who will speak for the women abused?
Who will speak so their voice will be heard? Oh, who will speak if you don’t? (Refrain)

Who will speak for the shunned and the outcast?
Who will speak for all people with AIDS?

Who will speak so their voice will be heard? Oh, who will speak if you don’t? (Refrain)

Who will work for the thousands of homeless? Who will work in the ghettos and streets?
Who will work so their voice will be heard? Oh, who will work if you don’t? (Refrain)

Who will care for the plants and the creatures? Who will care for the land and the sea?
Who will work so their voice will be heard? Oh, who will work if you don’t? (Refrain)

READING

- Catholic Health East declares that it holds “Commitment to those who are poor” as one of its cherished core values. “We give priority to those whom society ignores,” we say.
- Healthcare is about service and about need. Healthcare responds to the needs of persons in birth, in all of life’s processes, in suffering, and in death. Were there no need, there would be no healthcare. Need called our ministry into being and need sustains it.
- In the world community - and to a large extent within the U.S. society - there is significant agreement that healthcare is a basic human right. Religious traditions, including the Catholic tradition, are unequivocal about the existence of a basic right to healthcare. Religious traditions recognize that along with food, housing, and access to education, access to healthcare is essential to the development and maintenance of human dignity.
- As organizations within the Catholic tradition, the members of Catholic Health East are living witnesses to this recognition and the commitment it entails. We are inheritors of a firm belief that we are called to serve those who are most in need. We are also inheritors of a rich biblical tradition that speaks to us of God’s special care for those who are poor and most vulnerable.

REFLECTION

How has your organization demonstrated the commitment to meeting the healthcare needs of those who are poor and vulnerable in the communities that you serve?

Spend 7-10 minutes reflecting on one program/service that your RHC/JOA sponsors for persons who are poor. Answer the following questions related to that program/service:

Name of program/service:

Group(s) of those who are poor who are targeted by this program/service:

How was the need for this program/service first identified and how did that need get communicated to senior management within your RHC/JOA?

What criteria did your RHC/JOA use to determine whether your organization could/should address this need?

Describe your role in the identification, needs assessment, and decision making phases of this process and your current responsibilities relative to this program/service.

Is this program/service regularly reported in your social accountability/community benefit report?

How is this program/service communicated to potential recipients of service, to your RHC/JOA colleagues, your Board, and to the local community?

SHARING

Let's take some time to share our stories.

WHAT HAVE WE LEARNED?

What are our strengths in caring for those who are poor?

Where are our opportunities for growth in our provision of care for those who are poor?

What are our current threats in providing such care?

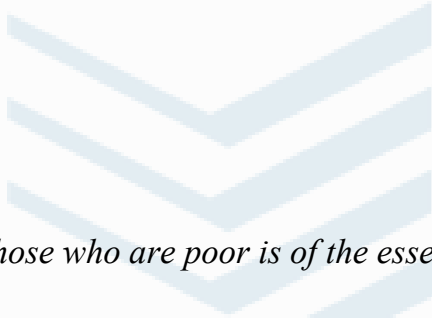
CONCLUDING PRAYER

Creator God, we join our minds, our hearts, and our voices with all persons and services that we have mentioned or thought about today. We renew our commitment to care for those who are in need, especially the most vulnerable, those who are poor, and those whom society ignores. May we continue to be a community of persons committed to being a transforming, healing presence within the communities we serve. Amen.

NOTES



System office colleagues who collaborated on this document are: Elaine Bauer, Vice President, Strategy Development; Ken Becker, Vice President, Advocacy and Government Relations; Philip Boyle, Vice President, Ethics; Mary Ann Carter, Vice President, Mission Services; Juliana Casey, IHM, Executive Vice President, Mission Integration; Cynthia Fry, Vice President, Revenue Management; Christine McDaniel, Manager, Advocacy and Government Relations; Randy Schultz, Vice President, Finance.



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CATHOLIC HEALTH EAST